

**A Thesis Submitted to  
The University of Birmingham  
For the Degree of  
Doctor of Clinical Psychology**

**Volume I  
Eating Disorders**

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September 2009

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## **Overview**

This thesis is submitted in partial fulfilment of the requirement for the degree of Doctor of Clinical Psychology at the School of Psychology, University of Birmingham. The thesis consists of two volumes.

## **Volume I**

This volume comprises two parts. The first part is a review of the literature regarding the role of attachment processes in the eating disorders. The second part is a qualitative study that investigates the personal meaning of eating disorder symptoms. The literature review suggests that although attachment processes appear to play a role in the development and maintenance of eating disorders, the precise relationship is unclear. This paper has been prepared for submission to the British Journal of Clinical Psychology. The empirical study uses interpretative phenomenological analysis in an effort to understand the sense people make of their eating disorder experiences. This paper has been prepared for submission to the Journal of Health Psychology. The Executive Summary is also submitted in this volume.

## **Volume II**

Five Clinical Practice Reports (CPR) are presented in this volume. The first report details the case of a young man experiencing panic attacks and anxiety, formulated from a cognitive-behavioural and psychodynamic perspective. The second report is an evaluation of a new assessment process within a Child and Adolescent Mental Health Service. The third report is a single-case experimental study of an older woman who was experiencing panic-attacks and separation anxiety. The fourth report is a case study of psychotic experiences in a middle-aged man with learning disabilities, formulated from a person-based cognitive therapy perspective. The fifth report is the abstract of an oral presentation of attachment-related considerations within work with a substance-misuse service.

All names and identifying features have been changed to ensure confidentiality.

## **Acknowledgements**

I would like to take this opportunity to acknowledge the support of my supervisors over the last few years, in chronological order: Joanna Grave, Nicky Bradbury, Charlotte-Anne Lloyd, Adam Huxley, Alex Copello, Emma Griffith, Catherine Amphlett and Peter Trower.

Thanks also to Newman Leung and Michael Larkin for their help with the research side of things. Their help certainly ensured that the research process was much less painful than it could have been.

Finally, thank-you to all the people who have been on the receiving end of my therapeutic endeavours during the last three years. I hope I was able to contribute something of use during the time we spent together.

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## **Executive Summary**

The work presented in Volume I of the thesis represents research undertaken during the completion of the doctorate level training course in clinical psychology at the University of Birmingham. It is comprised of two components: a review of the literature regarding links between attachment representations and eating disorder symptoms and an empirical paper that uses interpretative phenomenological analysis to explore young people's understanding of their eating disorder experiences.

**The relationship between eating disorders and attachment: An integrative review of recent research and concepts.**

**Introduction:** There has been much work that has considered the link between early experiences and the development of eating difficulties in later life. Attachment theory offers an attractive model for how early experiences may subsequently become manifested in eating disordered behaviour. The aim of the review is to consider recent work on attachment representations and related concepts in people with eating disorders.

**Findings:** There is a large and relatively coherent body of knowledge linking insecure adult attachment style and retrospective measures of childhood family experiences to eating difficulties. Furthermore, there is evidence that attachment style may link with other factors, such as adolescent development and maladaptive core-beliefs to influence the development and maintenance of eating disorder symptoms. However, longitudinal studies specifically examining the link between early attachment representations and subsequent development of eating disorder symptoms are lacking. Additionally, studies that examine the stability of attachment representations through the lifespan are also inconclusive.

**Conclusions:** Although there appears to be an association between attachment processes and eating disorders, the precise mechanism of this association remains unclear.

Furthermore, it appears that the extent to which traditional attachment theory alone can account for the development and subsequent maintenance of eating psychopathology is limited. Longitudinal research into models that incorporate attachment level representations alongside lifespan development, environmental and cognitive-mediational factors may shed more light on the processes involved.

### **The personal meaning of eating disorder symptoms: An interpretative phenomenological analysis.**

**Introduction:** Eating disorders, but particularly anorexia nervosa, have been considered 'ego-syntonic' in that people often believe that their behaviours fit with their sense of who they are. This can make anorexia nervosa difficult to treat, as individuals are reluctant to give up their eating disorder lifestyles. There is limited research on how people make sense of eating difficulties, and this has been limited to studies of discrete diagnostic populations (i.e. either anorexia or bulimia nervosa). Recently, however, more consideration has been given to the similarities between the eating disorders, and the potential of conceptualising them as one disorder with different variations (e.g. dietary restriction, bingeing, purging etc). Therefore the current research explores how young people with restrictive, bingeing, and purging experiences understand their eating difficulties.

**Method:** Eight women aged 18-29 with either current anorexia or bulimia nervosa were interviewed to discuss their eating experiences. Interview transcripts were analysed with interpretative phenomenological analysis in an effort to identify common themes in their experiences and how they made sense of these.

**Findings:** Five overarching themes were identified: the experience of the eating disorder as functional; gradual development of eating disorder symptoms; a cycle of eating disorder symptoms; negative effects of the eating disorder; ambivalence towards the eating disorder.

**Discussion:** It appeared that participants were aware of both negative and positive aspects of their eating difficulties, and as such, expressed ambivalence in their attitude towards

recovery. The eating difficulties appeared to provide them with some form of purpose, in that they made them feel special and as though they were able to accomplish something – especially in regard to the restrictive aspects. However, participants also discussed how much they disliked elements of the eating difficulties, especially the negative impact upon them and those around them, and appeared keen to reject the bingeing experiences. Exploring aspects such as these in therapeutic work with individuals with eating disorders may help people to understand the role of eating problems in their lives, and consider how they may be able to incorporate other sources of meaning that may be less destructive than their current eating difficulties.

# **The relationship between eating disorders and attachment: An integrative review of recent research and concepts.**

**Purpose.** There has been a diverse range of research and theoretical speculation on the association between insecure attachment and eating disorders. The current paper attempts to review recent findings and concepts involved in this research, and consider how these can be integrated into an understanding of the relationship between eating disorders and attachment theory.

**Method.** English-language papers were reviewed that involved a consideration of how attachment issues may be relevant to eating disordered populations and were published since the last available review of this area.

**Results.** Although there is evidence to suggest that eating disorders and attachment are linked, from the research evaluated in the current review, the nature of this link is unclear. There are a variety of concepts used to understand the potential role of attachment in eating psychopathology, and it appears that there are several areas where these concepts overlap. However, prospective longitudinal studies shed little light on the utility of specific conceptualisations of attachment theory, or the ability of this theory to predict eating psychopathology.

**Conclusions.** It appears that attachment difficulties remain an important factor for consideration in psychological therapy for people with eating disorders. However, research on lifespan attachment processes and eating disorders is disparate and far from coherent. It would perhaps be useful for future work to coalesce around related theoretical concepts (e.g. early maladaptive schemas) and test hypotheses with prospective longitudinal studies.

## **Introduction**

Psychosocial factors remain essential considerations in the aetiology and maintenance of eating disorders. One key theme that remains important in the eating disorders literature is that regarding the comparatively poor treatment options and outcomes for those with eating disorders – particularly for those with anorexia nervosa (Fairburn & Harrison, 2003; Fairburn, 2005). It has been suggested that eating disorders may serve some functional role within individual's lives and that this symptomatic functionality impedes therapeutic efforts (e.g. Slade, 1982). Although such functionality could cover a range of different domains within an individual, it has been suggested that eating disordered behaviour may represent a maladaptive attempt to cope with negative early (i.e. childhood) experiences, such as those discussed within the attachment literature (e.g. Ward, Ramsay & Treasure, 2000). As such, it is possible that eating disorders act as strategies for dealing with distress that results from dysfunctional attachment patterns. However, it is also possible that insecure attachment is just one of a number of related factors that play a role in the development of eating disorders. Therefore, in an effort to illuminate this area further, this paper will first evaluate whether psychopathological eating disturbances are associated with insecure attachment styles, before going on to outline other factors and concepts that have been studied that may link attachment representations with eating disorders. However, before considering the literature relating attachment styles to eating disorders, the main theoretical orientations that guide current thinking on the nature of attachment shall be outlined.

## **General attachment theory**

Attachment theory was developed by Bowlby (1969, 1977) to explain how early mother-infant interactions could influence the psychological development of children as well as future behaviour and psychopathology. The basic premise of attachment theory suggests that the child develops an internal working model of the world through interactions with the

primary care-giver, and this internal model is used as the basis for interaction with them. When this attachment is insecure (i.e. a negative view of self or other) individuals become vulnerable to psychopathology in later life (Bowlby, 1977). Original formulations of attachment used the 'strange situation' experimental observation as a basis for developing a model of child attachment behaviour, and delineated three main styles (the 'ABC' model), namely 'secure', 'avoidant' and 'resistant-ambivalent' (Ainsworth, 1979). These original styles observed in children have been since expanded upon by several authors, and consideration has been given to how such internal representations developed as a child can be manifested in adult behaviour. Bowlby (1977) emphasised the enduring nature of early attachment behaviours and internal representations, but it was Hazan and Shaver (1987, 1990) who argued that adult experiences such as love could be considered as an attachment process and that the same styles of attachment observed in children could be observed in adult relationships. Since then, much work has examined the field of adult attachment and the associated attachment styles (see Feeney & Noller, 1996).

Main and Solomon (1986) proposed an 'ABCD' model of attachment, with a fourth, 'disorganised' style incorporated into the theory that they argue includes child behaviours that could not easily be classified according to the ABC model. Their model suggests that when parents show inconsistent behaviour, so that a child may be at turns afraid of or reassured by their parents, confusion (or a 'loss' of attachment strategy) results, which represents the disorganised style of attachment. This has been expanded upon through work developing the Adult Attachment Interview – a clinical tool for identifying the attachment styles of adults – and the four styles of adult attachment (secure, dismissing, preoccupied, and disorganised) have been considered to map onto the child styles once the additional disorganised style has been incorporated into the child models (Van Ijzendoorn, 1995).

A complementary 4-category conceptualisation of attachment between adults (see Table 1) has been proposed by Bartholomew and Horowitz (1991), structured around a 2 dimensional representation of self and other as either positive or negative (see Figure 1).

Table 1: Adult romantic attachment styles (Bartholomew and Horowitz, 1991)

<b>Style</b>	<b>Description</b>
Secure	'Secure' individuals are self-confident, socially skilled, and likely to form relatively stable long-term relationships
Fearful	'Fearful' adults lack self-confidence, and are uncomfortable with emotional and psychological closeness, so tend to avoid long-term relationships
Dismissing	'Dismissive' style includes individuals with a positive sense of self and self-worth, but a negative view of other people – which leads them to adopt a sense of aloofness and a high value of independence
Pre-occupied	'Pre-occupied' adults lack self-confidence, are wary of rejection and abandonment but view others positively and are likely to fall in love quickly

		<b>Model of Self</b>	
		<b>Positive</b>	<b>Negative</b>
<b>Model of Other</b>	<b>Positive</b>	Secure	Preoccupied
	<b>Negative</b>	Dismissing	Fearful

Figure 1: Model of Self and Other and proposed attachment style (Bartholomew and Horowitz, 1991)



A further model of adult attachment, the dynamic maturational model (DMM), has been described by Crittenden (1995, 2005). In this model, Crittenden uses attachment theory to integrate biological and information processing theories into an account of early development that is also consistent with the theory behind various existing psychotherapeutic interventions. Crittenden (2005) suggests that individuals have a propensity towards processing either temporal information (about the direction and causality of events) or information about intensity (somatic feelings linked to contexts), which predisposes them to being either cognitively or affectively focused, respectively. The extent to which individuals may focus on cognition or affect is further influenced by the early environment, and Crittenden suggests that interactions with the primary care-giver in the early years influence the meanings children make of incoming information, such that they learn to rely predominantly on cognitive or affective information. This leads to two basic attachment styles – A and C, with a further style B representing a successful integration of both styles. In Crittenden's model, type A individuals tend to ignore feelings and act according to expected consequences, type C people tend to ignore expected consequences and act according to how they feel, while type B people usefully rely on both types of information. Relating this to attachment, for example, if a parent is inconsistent and unpredictable, so that a child is unable to rely on temporal information, the child may come to focus more on processing intensity- and affect-related information, and adopt a C type attachment strategy. This is similar to Ainsworth's original ABC model (Ainsworth, 1979); however, Crittenden (2005) has expanded the range of attachment strategies that may be used by people into a circumplex (see Figure 2). She suggests that people can draw upon a range of potential attachment strategies outlined in the circumplex based on their previous experiences, however, the use of particular strategies tends to develop at particular times in the lifespan of an individual.

Through all of the discussed models, attachment theory integrates ideas from psychoanalysis (e.g. 'drives' and early experiences) with those that are more cognitive (e.g. internal models of self). The main theoretical contention appears to be that experiences of

the relationship with the primary caregiver influence the development of an internal working model of attachment representations, which then influences how, as adults, we interact with others (Feeney & Noller, 1996). In this way, attachment difficulties have been used to understand a variety of mental health issues, including depression and anxiety (Platts, Mason & Tyson, 2005), psychosis (Berry, Barrowclough & Weardon, 2007), personality disorders (Page, 2001) and eating disorders (Ward, Ramsay & Treasure, 2000). The remainder of this review will now consider work that has used attachment theory in an effort to understand eating disorders.

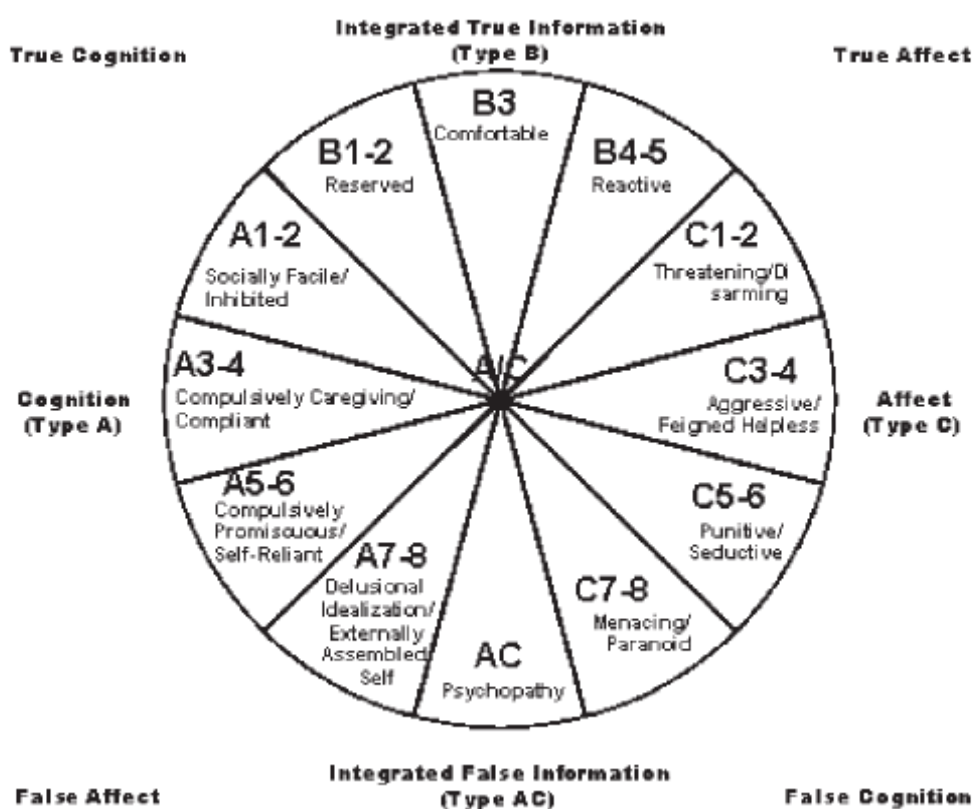


Figure 2: Patterns of attachment identified by Crittenden and applied in the DMM to the adult attachment interview

## **Early attachment theory and eating disorders research**

It was Bruch (1973) who initially identified the important role of early interactions between primary care-giver and infant in the development of eating disorders. She suggested that the individuals with anorexia nervosa struggled to separate their own needs from their mothers, and that the dyad developed an enmeshed relationship. In this sense, the symptoms of anorexia represent an attempt to construct an authentic self-identity in the face of an engulfing mother-child relationship. Although Bruch was not explicitly using attachment theory, Ward, Ramsay, Turnbull, Benedettini and Treasure (2000) found that their results on the Reciprocal Attachment Questionnaire (a measure of current adult attachment; West & Sheldon-Keller, 1994) from 127 people with a range of diagnosed eating difficulties referred to an eating disorder service supported the pattern of mother-daughter engagement that she outlined. In this study, comparatively high scores for both 'compulsive care-seeking' and 'compulsive self-reliance' in the eating disorder sample were taken to reflect attachment patterns of both anxious and avoidant styles, which they suggested also reflected the ambivalent nature of relationships with significant others (especially mother). This result has echoes of Bruch's writing on the mother-daughter relationship, and suggests that it was her work that was some of the first to use attachment-related ideas to understand eating disorders.

## **Previous review of attachment and eating disorders**

Since the early psychoanalytic work on the role of the primary care-giver in the development of eating disorders, there has been a variety of research into the role of attachment in eating psychopathology. The last known review (in English) was conducted by Ward, Ramsay and Treasure (2000) who concluded that attachment patterns were generally disrupted in people with eating disorders (i.e. they demonstrated insecure style

attachment patterns). They also suggested that where researchers had used the 'gold standard' of attachment assessment (the AAI), there appeared to be some form of differentiation between the eating disorder subtypes, with anorexic behaviours associated with dismissive attachment styles and bulimic behaviours associated with pre-occupied attachment styles (Candelori & Ciocca, 1998).

### **Is eating disordered psychopathology associated with an insecure adult attachment style?**

The previous review by Ward, Ramsay and Treasure (2000) concluded that there was some form of insecure attachment style typically observed in people with an eating disorder. Since the publication of that review, it seems that further work has attempted to explore the relationship between insecure attachment and eating disorders, with mixed results.

Broberg, Hjalvers and Nevonan (2001) found that within their sample of 145 young women with an eating disorder, participants tended to demonstrate insecure attachment patterns when compared to a randomly collected control sample of 315 young women, using a self-report measure of attachment style (the Relationship Questionnaire; Bartholomew & Horowitz, 1991). Furthermore, within their control sample, individuals with eating disorder symptoms also demonstrated insecure attachment styles. While this offers support to the general notion that eating disorders are associated with insecure attachment, they found no evidence that the different types of eating disorders were associated with different attachment styles, as suggested by others (Candelori & Ciocca, 1998; Ward, Ramsay & Treasure, 2000). The results of this study are made harder to interpret by the nature of the distribution of the attachment styles throughout the participants – a cluster analysis indicated 5 groups of attachment style, as opposed to the traditional 4 groups model (Bartholomew & Horowitz, 1991) used in the study. The authors use these groupings, which

appear to be a mix of insecure and secure styles, to explore attachment issues in their populations; however, it may have been more theoretically rigorous to offer a forced choice, so that individuals would have ended up in one of the 4 attachment models that fit with previous attachment research. Regardless, it is hard to tell from this study how these attachment styles relate to eating disorder symptoms, as there was no examination of the relationship between the scores on eating disorder symptoms (the Eating Disorders Inventory subscales in this study) and attachment scores. Thus, although it seems that individuals with an eating disorder are more likely to display insecure attachment styles, it is unclear from the Broberg, Hjalvers and Nevonan (2001) study as to why this may be the case.

Similarly, Ramacciotti, Sorbello, Pazzagli, Vismara, Mancone and Pallanti (2001) examined the attachment styles of six men and seven women with anorexia nervosa in an effort to explore the link between eating disorder symptoms and adult attachment style, using the AAI (Main & Goldwyn, 1984). As in the previous study, they found that their sample tended to show general insecure attachment (dismissing and pre-occupied styles), although there was no particular pattern of attachment style linked to anorexia subtype. However, possibly because the study uses the AAI, which can be time-consuming to administer and score, the sample size was small, which may explain this failure to replicate a link between attachment style and eating disorder subtype. Interestingly, this study does report a greater proportion of insecure attachment in males than females – a result that has not previously been explored in eating disorders literature, presumably due to the reduced incidence rates in males. Subsequently, however, Huprich, Stepp, Graham and Johnson (2004) have found more associations between insecure attachment and disordered eating attitudes in female students than males (in an overall sample of 141), which makes the interpretation of the Ramacciotti et al study difficult.

Some studies have attempted to examine the differences between eating disorder subtypes. Latzer, Hochdorf, Bachar and Canetti (2002) used the Adult Attachment Scale (Hazan & Shaver, 1987) to assess attachment patterns in 25 people with anorexia and 33 with bulimia nervosa in relation to their family environment and found that both sets of participants tended to demonstrate insecure attachment. Although there was a trend in their data to suggest that the bulimic group were more anxious/ambivalent, and more avoidant, there were few statistically significant differences between the two eating disorder subgroups. Other self-reported family factors, however, such as family cohesiveness and encouragement for personal growth, did seem to distinguish bulimic participants from controls, but not anorexic participants. Zachrisson and Kulbotten (2006) provide further support for this lack of specific associations between eating disorder subtypes and attachment style. They explored the relationship between attachment style and eating disorder symptoms through an analysis of 20 adult attachment interviews with women with anorexia nervosa. In contrast to previous studies, they analysed the AAI's using Crittenden's dynamic maturational method (DMM) for coding (previous studies using the AAI have used Main & Goldwyn's (1984) scoring system) in an effort to provide a more precise fit to the attachment styles observed in clinical samples. In a similar fashion to previous research, however, although all participants displayed insecure attachment, there was no evidence that eating disorder subtypes were related to specific attachment styles.

In another study using Crittenden's DMM approach to adult attachment, Ringer and Crittenden (2007) found that none of their sample of 62 women with anorexia (both subtypes) or bulimia displayed secure attachment. They did find some limited evidence to support the suggestion of Ward, Ramsay and Treasure (2000) that different eating disorder subtypes utilised particular attachment strategies; however, there was considerable overlap between the subgroups. In a qualitative exploration of the AAI's used in the study, the authors also comment on the emergent links between the apparent attachment style of the eating disordered participant, and their current and recalled family situation (Ringer &

Crittenden, 2007). This finding suggests that difficult family dynamics may be important in understanding eating disorders, but as it is not longitudinal, it is impossible to say whether these dynamics influenced the development of the disorder or are a product of it.

When considering family dynamics and attachment in eating disorders, a study by Dallos and Denford (2008) offers some support to the notion that they may be important in understanding the development and maintenance of the disorders. They interviewed four families of people with anorexia nervosa using a semi-structured interview based on the AAI, and analysed the data using a combination of interpretative phenomenological analysis and the Crittenden (1997) method. The authors identified 5 key themes in their analysis: 'false or fragile reality', 'troubled relationships, with corrective scripts', 'arguments and triangulation' 'lack of comfort and receiving/giving care' and 'negative relationship with and memories of food' (Dallos & Denford, 2008). While this study did not classify people according to attachment style, the key themes do seem to reflect those processes often thought to be associated with an insecure attachment style, and add some to support to the notion that attachment style is associated with the development of eating disorders. However, as the study limits itself to a consideration of anorexia nervosa, and because it does not classify people according to the attachment strategies they used, it offers no support for the notion that eating disorder subtypes can be differentiated according to attachment style.

Tereno, Soares, Martins, Celani and Sampaio (2008) examined the relationship between attachment styles, parental rearing memories and therapeutic engagement in 30 people with anorexia, 27 with bulimia, and their respective therapists and parents. They found that while there was no difference between the anorexics and bulimics on measures of attachment (they used the revised AAS) parental rearing or therapeutic engagement, there were differences between them and the controls (n=35). Specifically, they found that the

control group was less anxious and avoidant, while bulimics reported more parental rejection than controls.

Troisi, Massaroni and Cuzzolaro (2005) used the Attachment Style Questionnaire (ASQ) and the Separation Anxiety Symptom Inventory (SASI) to measure the attachment styles and early separation anxiety of 78 women with eating difficulties (including anorexia, bulimia nervosa, or eating disorder not otherwise specified) and compared these to a control group (n=64). They found that while the eating disorder groups were no different from each other on these measures, they did score more highly than the control participants on several subscales of both measures. The bulimic group were only significantly different from the control participants on the 'need for approval' subscale, which represents anxiety regarding being abandoned by others. In contrast, the individuals with anorexia were significantly different from the control group on the discomfort with closeness, need for approval and preoccupation with relationships subscales, with the former representing an avoidance-type attachment style and the latter both representing concerns about abandonment. As such, this study offers no support to the notion that the different eating disorders are typified by differences in attachment style; however, the authors suggest that insecure attachment may predispose individuals to general psychopathology, and that it is other factors that influence the type of disorder that develops. Indeed, there is more recent research indicates that attachment style alone is insufficient to explain the pathogenesis of eating disorders, and that other factors need to be considered in conjunction with models of insecure attachment.

Troisi, Lorenzo, Alcini, Nanni, Pasquale and Siracusano (2006) again used the ASQ and SASI to examine attachment and separation anxiety, in people diagnosed with anorexia (n=31) and bulimia (n=65), and how they may be linked to body dissatisfaction (assessed via the Body Shape Questionnaire; Cooper, Taylor, Cooper & Fairburn, 1987). They found that scores on the SASI and the 'need for approval' subscale of the ASQ positively predicted scores on the body dissatisfaction scale once the 2 groups had been collapsed.



People who score highly on the need for approval scale typically have a pre-occupied attachment style, which the authors suggest may predispose people to developing concerns regarding body image. Again, they reported almost no differences between the scores from their anorexic and bulimic group, with the only difference being that bulimics scored more highly than anorexics on the ASQ subscale 'preoccupation with relationships'.

This brief review of the research conducted since the Ward, Ramsay and Treasure (2000) suggests that while eating disorders are associated with insecure attachment, there is still limited evidence to support the suggestion that the two subtypes are differentially associated with specific attachment styles. However, the research that has examined this area has typically been of a limited sample size, and has not always used the 'gold standard' of the AAI, which may explain this lack of evidence. As such, despite the evidence that there is a link between attachment patterns and eating disordered psychopathology, it seems that the nature of this link is still unclear. Recently, there has been speculation regarding the processes through which disordered attachment patterns may exert their potentially psychopathological effects. Barth (2003) has explored the issue of separation-individuation within college students with eating disorders, and how this developmental process may be related to attachment representations.

### **Young adult development and attachment processes**

The late-adolescent stage of development is typically characterised by a search for an answer to the question 'who am I'? (Rosenberg, 1979), and it is a period where individual beliefs about the self and others are explored (Harter, 1999). Individuation, or the process of separating from the family and developing a separate self-identity (Mahler, Pine & Bergman, 1975), appears to be one of the fundamental tasks of adolescence (Lapsley, 1993), and it has been argued that healthy transition through this stage is only possible in the context of a secure attachment (Barth, 2003). In her work with students with eating disorders, Barth

suggests that problematic attachment processes make it difficult for many people with eating disorders to negotiate this stage of development, and there is some subsequent evidence to support the notion of developmental issues at this stage in people with anorexia nervosa (Fox, Harrop, Trower & Leung, 2009). However, whether such individuation processes contribute to the development of eating difficulties, or whether having eating difficulties makes adolescence more problematic is unclear. Interestingly, in a longitudinal study of 88 young Israeli adults experiences of being conscripted to military service, attachment representations showed little association with subsequent measures of separation-individuation (Scharf, Mayseless & Kivenson-Baron, 2004). However, in the same study, there were some data to suggest an interaction between attachment representations and situational-evaluation aspects of military service in the prediction of individuation scores. Specifically, it seems that securely attached individuals experienced greater individuation when they either evaluated their time in the military as positive or were in a command position, compared to individuals with a dismissing attachment style (Scharf, Mayseless & Kivenson-Baron, 2004). As such, it remains to be seen whether specific insecure attachment styles present more challenges to normative separation-individuation processes than others would, but never the less, it remains possible that the developmental tasks around late-adolescence may be made more difficult if individuals have an insecure attachment style to begin with.

### **Attachment and core-beliefs**

Another potential pathway through which insecure attachment patterns could lead to psychopathology (including eating difficulties), is that of the cognitive schema (Platts, Tyson and Mason, 2002). Beck defines cognitive schemas as “structures for screening, coding and evaluating the stimuli that impinge upon the organism” (Beck, 1967, p 283) and suggests they are responsible for cognitive distortions often linked to psychopathology. The term ‘core-belief’ is often used interchangeably with the term schema, however, while schemas

are the specific networks of knowledge that become selectively activated following input into the cognitive system, core-beliefs are perhaps best considered as the overarching verbal themes apparent in the activated networks (James, Southam & Blackburn, 2004). As such, while cognitive schemas are not open to conscious appraisal and reflection, core-beliefs are, and it may be that many purported measures of 'schemas' are in fact, measures of the linguistic representations of the overarching thematic content of the schemas (i.e. core-beliefs; Fox, 2007; James, Southam & Blackburn, 2004). Regardless, there is now a consistent body of knowledge linking eating disorder psychopathology to maladaptive core beliefs (e.g. Cooper, 2005; Jones, Leung & Harris, 2006; Leung, Waller & Thomas, 1999) which suggests that an understanding of the association between attachment representations and core-beliefs is important when considering the role of attachment in the development of eating difficulties.

In a review of the two areas, Platts, Tyson and Mason (2002) suggest that attachment theory could act as the link between early experiences and the development of core-beliefs. They speculate that individual differences in attachment could be conceptualised as being due to the beliefs that people have about themselves and others (i.e. similar to Bowlby's working model). Empirical support for this suggestion comes from a study by Mason, Platts and Tyson (2005) who found that in a general population of seventy-two adults with mental health difficulties, different patterns of core-beliefs were associated with different attachment styles. Furthermore, Maier, Bernier, Pekrun, Zimmerman & Grossmann (2004) found evidence that attachment style in a normal population of thirty-eight young adults was linked to response latencies on a cognitive priming task, providing some limited support for the theoretical contention that attachment representations may be linked to cognitive processing (i.e. schemas). A study by Blissett, Walsh, Harris, Jones, Leung and Meyer (2006) also provides some further evidence for a link between attachment and core-beliefs, as they found that core-beliefs, as measured by Young's Schema Questionnaire (YSQ; Young, 1998) explained scores of adult attachment representations within a young female

undergraduate population (n=206). However, they do emphasise that not all core-beliefs are necessarily primarily related to attachment experiences, and argue that core-beliefs may also develop through later developmental processes of peer group and romantic socialisation (Blissett, Walsh, Harris, Jones, Leung & Meyer, 2006). In a similar study with 389 undergraduates, Weardon, Peters, Berry, Barrowclough and Liversidge (2008) found associations between self-reported negative self-evaluative core-beliefs and insecure attachment; however they found little association between negative other-evaluative beliefs and insecure attachment. Furthermore, they also found that their observed relationship between maternal care-giving and negative self-evaluative belief scores was mediated by anxious attachment.

These results add some weight to the idea that core-beliefs may be linked to attachment representations in the general population; however the precise role of core beliefs in the relationship between psychopathology (including eating disorders) and attachment difficulties is unclear. Young, Klosko and Weishaar (2003) suggest that just as the internal working model is developed in response to interactions between the child and those in their immediate environment (i.e. care-givers), core beliefs become elaborated early in development in response to the environment. At what point attachment representations and core beliefs overlap, is still unclear; however, based upon the work reported on in the review, it may be that a generic working model develops very early on in childhood which is then elaborated into more specific core-beliefs later in childhood and early adulthood. It may be that some particular forms of core-belief develop earlier than others, such that ones regarding the fundamental nature of self and other (e.g. 'I am defective') are more closely linked to early attachment representations than others.

Returning to the link between eating-disorders and attachment, it seems that although there is evidence of insecure attachment being associated with dysfunctional core-beliefs in general psychopathology, it is unclear how this may relate specifically to the aetiology and

maintenance of eating disorders. Further research that examines such relationships in people with eating disorders is needed to clarify the situation.

### **Parental care-giving and eating disorders**

Clearly, following attachment theory, attachment representations would be expected to be influenced by the care received when an infant (Bowlby, 1977). Given that the internal working model of self and other is thought to be influenced primarily by the care received by the child, then it seems appropriate to consider of the role of the parents (or alternative primary care-givers) in the development of secure attachment. Indeed, theorists have considered the impact of parental care on the development of the self (e.g. Fonagy & Target, 1997; Guidano & Liotti, 1983) and research has linked particular types of (albeit self-recalled) parental care to the development of eating disorders (e.g. De Panfilis, Rabbaglio, Rossi, Zita & Maggini, 2003; Leung, Thomas & Waller, 2000; Rhodes & Kroger, 1992). However, the case is far from clear-cut, with Castro (2000) concluding that although there is some evidence for the role of parental rearing practices in the development of bulimia (especially overprotection and rejection), the same could not be said for anorexia nervosa. More recently, Jones, Leung and Harris (2006) found that, in a study with sixty-six women with an eating disorder, the observed relationship between paternal rejection and overprotection and eating disorder scores was mediated by core-beliefs of abandonment, defectiveness/shame and vulnerability to harm. Similarly, Meyer & Gillings (2004) found that abandonment core-beliefs mediated the relationship between paternal overprotection and scores on a measure of bulimic symptoms in a sample of 102 non-clinical young women.

Perry, Silvera, Neilands, Rosenvinge and Hanssen (2008) used structural equation modelling to examine the relationship between perceived parental care, self-concept and eating psychopathology in 166 undergraduate students in the USA and 233 in Norway. They found that negative self concept was associated with a parenting style of low care and

over-protection, which was also associated with eating disturbances. This would seem to suggest that this particular type of parental bonding with the child is associated with the development of a negative model of self (and therefore insecure attachment), which is then linked to the development of eating psychopathology. However, given the conclusions of Castro (2000), that there is a potential difference in the contribution of parental rearing practices in the development of anorexia and bulimia, it is important to discriminate between the subtypes of eating psychopathology. Unfortunately, the Perry, Silvera, Neilands, Rosenvinge and Hanssen (2008) study used a measure of eating disorder psychopathology that does not differentiate between eating disorder subtypes (the Eating Disorders Scale). However, the authors do report that high scores on this scale tend to be associated with the identification of more bulimic-type eating disorders, which suggests that their model may reflect the trend found in previous research that links particular parental practices with bulimic symptomatology (Castro, 2000; Jones, Leung & Harris, 2006; Meyer & Gillings, 2004).

In a study that examined parental rearing practices (using the Parental Bonding Instrument) reported by 43 people with anorexia, Canetti, Kanyas, Lerer, Latzer and Bachar (2008) found that participants rated their mothers and fathers as less caring than 33 non-clinical controls, while they rated their fathers as more controlling. It was this tendency to score fathers more highly on a measure of 'affectionless control' that distinguished the anorexic from the non-clinical groups. Interestingly, the authors also report a relationship between eating disorder symptom scores and the participants' mothers' report of their relationship with their own mothers (i.e. the anorexic participants' grandmothers). Taken together, these results suggest that anorexic eating disorder symptoms may be associated with perceived parental rearing-practices, and that these may even be passed through generations; however the precise nature of this link is still unclear.

Limited support for an association between parental bonding or rearing practices and eating disorders can be found in a study by Furnham and Adam-Saib (2001), who examined parental bonding in 168 non-clinical young women from different cultural backgrounds to examine the association (if any) between culture, parental practices and eating difficulties. They found that although British-Asian young women had higher self-reported eating disorder and parental overprotection scores than their white counterparts, the best predictors of eating disorder symptomatology were body-dissatisfaction scores. Furthermore, there is some evidence of lower self-reported paternal and maternal care scores in chronically ill people with anorexia nervosa, although the sample size in this study was small (n=15) (Bulik, Sullivan, Fear & Pickering, 2000).

In summary, although there appears to be a link between parental rearing practices and the development of eating disorders, the precise nature of how parental behaviours are translated into insecure attachment and how this may be linked to the development of eating difficulties is far from clear. For example, are all individuals who receive a particular style of parenting vulnerable to the development of psychopathology? Or is there a (potentially genetically-based?) personality profile that is more susceptible to the development of negative internal working models than others? If so, which parental styles are associated with this? And would this combination lead to the development of general distress or specifically eating disorders? Furthermore, many studies limit themselves (perhaps necessarily, due to resource limitations) to retrospective report from adults. It may be that measures of 'attachment' or 'bonding' are actually measuring the participants' ability to remember negative parenting practices, or to selectively recall negative memory regardless of the episodic content. Ideal studies would be longitudinal in nature that measure actual parenting styles, and compare this with subsequent attachment style that is developed in adulthood. However, given the resources required for such research, it is perhaps unsurprising that studies using such methodology are comparatively scarce.

## **Longitudinal aspects of attachment**

Attachment theory suggests that representations of self and other developed when an infant influence the interactional style of the child (Bowlby, 1977) and that these representations also influence adult interactions (Feeney & Noller, 1996). As such, we would expect there to be some form of continuity between attachment style when initially assessed as an infant, and attachment style through the lifespan. This is especially important when considering whether attachment style is associated with the development of psychopathology, as in the case of the current review.

The evidence for lifespan continuity of attachment representations is far from clear, and although a thorough review of this area is out of the scope of this review, a brief consideration of the main findings is warranted. Wartner, Grossman, Fremmer-Bombik and Suess (1994) found that between the ages of 1 and 6 years old, attachment style (as assessed using the strange-situation and subsequent behavioural observations and assessments) stayed the same for 82% of their sample of 40 children. This offers some support to the theory that the pattern of attachment strategies development remains consistent after the first year in a normative sample. However, Bar-Haim, Sutton, Fox and Marvin (2000) found that between the ages of 14, 24 and 58 months, only 29% of their total cohort (n=48) remained in the same attachment category when assessed with modified versions of the strange-situation. Furthermore, they found that mothers whose children had switched attachment categories had higher scores for experiences of negative life events in their recent lives, which suggests that the children's attachment to their mothers may have modified as a result of the negative experiences in their lives. Regardless, these results do not support a continuity model of attachment through the lifespan. This result is supported by a follow-up to the Wartner, Grossman, Fremmer-Bombick and Suess (1994) study, that reported there was no continuity between attachment as assessed at age 1, 6 and 16 years old using versions of the strange-situation and the adult attachment interview (Becker-Stoll,



Fremmer-Bombik, Wartner, Zimmermann & Grossmann, 2008). Interestingly, however, those teenagers that did show a switch in the attachment classification did report slightly more 'risk factors' (e.g. parental divorce, bereavement, mental illness of relatives etc) than those who were stable across time. The authors report that there is evidence in the literature of both continuity and discontinuity in attachment style over time, but that all of them demonstrated that discontinuity was more likely in those participants who had experienced negative life events (Becker-Stoll, Fremmer-Bombik, Wartner, Zimmermann & Grossmann, 2008).

In regard to eating disorders and attachment style, if attachment style is considered relatively stable over time, then one may predict particular attachment styles as being linked to the development of particular eating disorder symptoms (e.g. as suggested by Ward, Ramsay & Treasure, 2000). However, it appears that there is at least some level of flexibility in the longitudinal development of internal working models, which makes the link between attachment style and eating disorders more problematic. It seems that attachment representations may change over time, which makes it hard to predict with any certainty how they interact with other variables to influence the development of psychopathology. This is compounded by evidence that links negative life experiences to attachment discontinuity (e.g. Bar-Haim, Sutton, Fox & Marvin, 2000), which suggests that attachment style (and therefore internal working models) may be fluid and responsive to subsequent environmental change. If this is the case, and individuals switch their attachment style, what does this mean for the internal working model? It may be that such fluidity observed in attachment style may be a reflection of the measures used to assess it, rather than 'true' change (i.e. measurement error). However, if it is not as stable as initially supposed (e.g. Bartholomew & Horowitz, 1991), then a more elaborate mechanism than currently offered by general attachment theory (e.g. model of self/other) is needed to explain how early parental-child interactions may influence subsequent lifespan development (including the onset of eating disorders). It may be that work that links core-beliefs to attachment

representations (e.g. Blissett, Walsh, Harris, Jones, Leung & Meyer, 2006) may offer some level of explanation beyond that offered by attachment theory in isolation.

### **Do attachment difficulties precede eating disturbances?**

Even if attachment style is more fluid than previously hypothesised, the literature considered so far appears to suggest that early child-parent experiences play a role in the development of particular ways of relating to others, and that people vary in their ability to adapt their interpersonal beliefs and behaviours. In the face of distressing interpersonal situations, it may be that eating disorders offer some form of functional relief (e.g. Slade, 1982). If eating disorders do indeed serve some functional purpose regarding dysfunctional attachment, not only should eating disorders be associated with insecure attachment styles, but the attachment patterns should also precede eating disorder psychopathology. However, in order to establish whether eating disordered symptoms play a functional role in mediating the distressing effects of insecure attachment styles, longitudinal studies are required that examine the onset of eating disordered symptoms.

Burge, Hammen, Davila, Daley, Paley, Lindberg et al (1997) interviewed one-hundred and thirty-seven high-school seniors (18-year olds) with the Structured Clinical Interview for DSM-III-R (SCID), and asked them to complete some self-report measures including the Revised Adult Attachment Scale (RAAS) and the Inventory of Parent and Peer Attachment (IPAA; a measure of attachment to peers and parents). Eating disorder symptoms were measured through the SCID, although only two women were considered 'clinical' at the start of the study, and one at 12 month follow-up. Their data suggest that attachment cognitions measured by the RAAS at the start of the study predicted between 4 and 21% of the variance in eating disorder symptoms at 12-month follow-up, but only as an interaction with initial symptoms. Low scores on the RAAS subscale of 'closeness' (the extent to which the individual is comfortable with emotional closeness and intimacy), along with previous

symptoms, appeared to be the best predictor of eating disorder symptoms at 12-month follow up, providing some evidence that attachment may play a role in the development of eating disorder symptoms. In a similar fashion to the RAAS subscales, an interaction between initial symptoms and IPAA-parent subscales contributed to between 4 and 7% of the variance observed in eating disorder symptoms, while an interaction between initial symptoms and IPAA-peer subscales also contributed to between 3 and 16% of the observed variance in eating disorder symptoms. Taking into account both of these scales, and their relative contributions to eating disorder symptoms in this sample, it seems that attachment constructs and initial eating disorder symptoms increase vulnerability to the development of further eating disorder symptoms. However, this sample had only a few clinical participants, and the attachment measure was self-report, and may therefore be open to any number of reporting biases (e.g. ego-defence).

Colton, Olmstead, Daneman, Rydall and Rodin (2007) followed up one-hundred and six 9-13 year old girls who had Type 1 diabetes 12 months after an initial self-report (IPAA) and interview (Children's Eating Disorder Examination; cEDE) assessment session. They used the cEDE to measure the presence or absence of 'eating disturbed behaviour' (which they defined as dieting, bingeing, vomiting, laxative abuse, insulin abuse and excessive exercise) at both time-points, while parents also complete the Eating Attitudes Test (EAT-26). They found that, amongst other predictors, BMI and 'attachment to mother' subscale of the IPAA together accounted for 15% of the variance in new-onset eating-disturbed behaviour at 12-months follow-up. This offers some support to the notion that eating-disordered behaviour may occur as a result of attachment issues, although the population is not typical of traditional eating-disordered populations, and therefore may not be considered particularly representative or the results very generalisable. Interestingly, BMI, 'self-worth', and maternal EAT-26 scores at Time 1 together explained 35% of the variance in cEDE scores at 12 months follow up, suggesting that mothers - and particularly mother's eating attitudes - are important in understanding eating-disordered behaviour. Given the age of the

participants (9-13 years old), it is perhaps not particularly surprising that mothers' eating attitudes impact upon their daughters' eating behaviour, as it is probable that they are living at home, with their mothers, who are likely to have at least some control over family food shopping and eating habits. This finding supports work that links maternal influences on weight and dieting concerns (e.g. Hill & Franklin, 1998).

Eating problems in childhood have been identified as risk-factors for the development of eating disorders in adults (Kotler, Cohen, Davies, Pine and Walsh, 2001). A study of 87 children and their families by Hagekull & Bohlin (2004), found that insecure attachment (as assessed via the strange-situation when an infant) was associated with picky-eating behaviour when the child was in middle-childhood (between 7 and 8 years old). Furthermore, low parental perceived control was also associated with picky-eating behaviour, which may be another reflection of how parental attitudes may influence the development of eating disorders. Similarly, a longitudinal study that interviewed 782 pairs of mothers and children during childhood, adolescence and adulthood found that maladaptive paternal behaviour was particularly associated with adult eating disorders, as assessed with the Diagnostic Interview Schedule for Children (Johnson, Cohen, Casen & Brook, 2002).

From the limited research conducted, it appears that childhood family dynamics and interactions may increase the risk of the later development of an eating disorder, although the mechanism through which such variables may exert their psychopathogenic effects is unclear. While there is some limited evidence to suggest that insecure attachment may precede eating disturbances, the relationship between attachment and subsequent development of eating disorders remains to be elucidated. As previously mentioned, it is possible that eating disorders may play a functional role in mediating distress within an individual (e.g. Slade, 1982), such as that caused by a dysfunctional attachment style; however, there is no direct evidence that this is the case.

## Discussion

This review has attempted to consider the relationship between attachment theory and eating disorders, following on from the review by Ward, Ramsay and Treasure (2000). The conclusion of the Ward, Ramsay and Treasure (2000) review that eating disorders were associated with insecure attachment still appears to be accurate; however, their suggestion that different forms of eating disorder may be associated with different forms of attachment does not appear to have garnered much evidence to support it. Subsequent research has focussed on the relationship between eating disorders and other attachment-related concepts, such as parental rearing practices, core-beliefs and separation anxiety. However, the retrospective nature of the assessment of attachment style makes it problematic to offer predictive models of the relationship between attachment concepts and eating disorders. Furthermore, the nature of attachment patterns as enduring throughout the lifespan is not completely supported in the longitudinal literature, which suggests that attachment tendencies may have more complex relationships with other environmental factors than perhaps first considered.

Of the attachment models used to guide research into this area, Crittenden's model (1995, 2005) offers perhaps the most comprehensive account of how early experiences can influence later attachment styles and subsequent behaviour. In her model, individuals use particular attachment strategies only when they possess the ability to do so, and this ability depends on an individual's biopsychosocial development. In this way, eating disorders could be seen as one of the more advanced responses to insecure attachment that are available in an individual's repertoire. This model also moves attachment literature away from conceptualising attachment as a categorical variables to more dynamic or continuum models. This allows the model to account for how environmental factors external to the attachment relationship may modify attachment style through the lifespan (e.g. Becker-Stoll,

Fremmer-Bombik, Wartner, Zimmermann & Grossmann, 2008). In the context of the family system, it may be that eating psychopathology may be used as a dysfunctional attachment strategy, by triggering desired responses in the parents towards the daughter (Ringer & Crittenden, 2007). In this way, the eating disorder serves a purpose within the individual's life, albeit a dysfunctional one, which may explain why eating disorders (particularly anorexia) remain resistant to treatment (see also: Fox & Leung, 2009; Slade, 1982).

The retrospective nature of the measures of adult attachment make the development of an aetiological model of how eating disorders may be linked to attachment problematic, especially when considered in the light of the evidence of attachment discontinuity through the lifespan. Our understanding of the relationship between attachment and eating disorders is most likely hampered not only by the resources required to conduct longitudinal research, but also by the low incidence rates of eating disorders in the general population (Fairburn & Harrison, 2003). Further research is required that measures attachment processes over time in an effort to understand how they may be linked to the development of eating disorders. If attachment representations are indeed instrumental in some way in the development of eating psychopathology, then it would be important to incorporate an understanding of the implications of these into early detection, intervention and treatment services, as well as those designed for prevention.

The difficulty with interpreting the attachment literature seems to be the relatively non-specific nature of the relationship between eating disordered psychopathology and attachment representations. The range of research discussed suggests that the type of disordered attachment is not sufficient in itself to explain the form the eating disorder may take, which may explain why more recent research has looked to additional variables to explain the relationship between eating disorders and attachment. However, it is possible that the exploration of the relationship between the two variables of interest is hampered, not only by the complexity of the relationship but also by the nature of the constructs

themselves. The discontinuity aspects of attachment theory have already been considered here, however, there is also disagreement regarding the classification of eating disorders. Specifically, there has been some suggestion that the current conceptualisation of eating disorders as distinct diagnostic entities, split into anorexia, bulimia (excluding the potential diagnostic criteria of binge-eating disorder) and EDNOS is unhelpful and phenomenologically unsound (Fairburn, Cooper & Shafran, 2003). The alternative 'transdiagnostic' approach advocated by Fairburn and colleagues eliminates distinct categories for the eating disorders, and emphasises the amount of similarity between the groups, suggesting that several particular common themes, traits and experiences underlie all eating disorders – a point expanded upon more recently by Waller (2008; see also Strober, Freeman, Lampert & Diamond, 2007). Such an approach may offer potentially fruitful new avenues of research in exploring the link between attachment and eating disorders, although it is not without its critics (Birmingham, Touyz & Harbottle, 2009).

Another alternative is to look at lifespan developmental models of psychopathology that focus on the developmental challenges that an individual faces at various stages of their lives (Hendry & Kloep, 2003). Eating disorders typically - though not exclusively - develop during adolescence (Fairburn & Harrison, 2003), which is a critical period for the healthy separation and development of the self from the parents. Attachment theory therefore offers a potentially useful model for understanding how internal representations of self and other may influence the development and maintenance of eating-disorders at this stage of life. However, attachment models are limited by their focus upon the history of the individual in relative isolation from their social-cognitive developmental stage, and there other developmental processes that may usefully explain aspects of eating psychopathology beyond that offered by attachment-based models (e.g. Barth, 2003; Fox, Harrop, Trower & Leung, 2009). Although attachment models (particularly Crittenden's) examine the nature of current self-other relationships in the context of childhood experiences, they neglect to offer any specific consideration of how these may be mediated by the social environment. This is

particularly important when considering mental health difficulties such as psychosis (see Berry, Barrowclough & Weardon, 2007) and the eating disorders, as they tend to occur during adolescence, where social interactions are considered of paramount importance in normative development through this period (Vartanian, 2000). Further investigation of the potential links between attachment representations and developmental processes of adolescence may shed some light on the nature of attachment disturbances in eating disorder populations.

In conclusion, it appears that although eating disorders and insecure attachment are associated with each other, our understanding of the relationship is still very limited. It is impossible to say from the empirical literature, for example, whether insecure attachment precedes the development of eating disturbances. From a theoretical standpoint, it seems highly probable that insecure attachment in childhood is a risk factor for the development of eating disorders; however, the evidence for such an assertion is limited. Furthermore, there appears to be only minimal evidence for even the vaguest mechanism linking insecure attachment to the development and maintenance of eating disorders. The retrospective nature of attachment questionnaires means that, while useful in assessing *current* adult attachment style, and when viewed in the light of evidence of the discontinuity of attachment styles, they offer very limited information on the contribution of early childhood experiences to the development of eating disorders. This is an essential flaw in the attachment literature to date, and further research that examines the longitudinal course of attachment representations over the lifespan in a wide range of families is necessary to remedy this situation. Of course, such research would be resource-intensive, but until the fundamental processes of attachment are empirically illuminated then we must be wary of the inferences made from the literature. This is not to say that important discoveries on the nature of current adult attachment processes and their role in the experiences of people with eating disorders have not been made in the literature reviewed here – on the contrary. However, it is important that we do not make assumptions that go beyond the available data. From the



literature reviewed here on the role of adult attachment in eating disorders, it seems that people with an eating disorder tend to recall difficult relationships with their parents (e.g. Ramacciotti, Sorbello, Pazzagli, Vismara, Mancone & Pallanti, 2001; Zachrisson & Kulbotten, 2006), display difficulties in interpersonal situations (e.g. Dallos & Denford, 2008), and these may be associated with dysfunctional beliefs regarding self and the world (e.g. core-beliefs; Cooper, 2005; Jones, Leung & Harris, 2006). These studies offer limited support to the general notion that attachment difficulties may be important in adults with eating disorders, however, they do not offer support to a particular model of how attachment issues may be relevant to the development and maintenance of eating disorders through the lifespan. While it is still unclear from the literature how early childhood experiences and subsequent attachment representations may influence the development and presentation of eating disorders in adults, it appears that it is important to consider the implications of current adult attachment difficulties in therapeutic work with people with eating disorders.

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# **The personal meaning of eating disorder symptoms: An interpretative phenomenological analysis**

*Note: This section has been written for submission to Journal of Health Psychology, and as such is presented in appropriate journal format. References are made to first, second and third authors, however, none of the text presented in this section was written by the second or third authors.*

## **Abstract**

There is some limited previous research regarding the sense that people make of their own eating disorder symptoms. However, given the comparatively low recovery rates for eating disorders the current study aimed to explore the personal meaning of eating disorder experiences in an effort to illuminate this area further. Eight people with a variety of eating disorder experiences were interviewed regarding their experiences of their eating disorder. These conversations were then analysed using interpretative phenomenological analysis in an attempt to construct a framework for understanding the personal world of the interviewees. The analysis identified 5 particular overarching themes in participants' accounts of their experiences: a gradual development of the eating disorder through time; a cycle of eating disorder symptoms; the experience of the eating disorder as functional; negative effects of having an eating disorder; ambivalence towards the eating disorder. These themes add to our knowledge of the different ways that people make sense of their eating disorder experiences, which contributes to our understanding of the role of eating disorder experiences within a person's life. The clinical implications of the research are discussed.

*Keywords:* personal meaning, eating disorder, interpretative phenomenological analysis

## Introduction

There is a great deal of interest in the role of eating disorder cognitions and behaviours in the maintenance of anorexia and bulimia nervosa (e.g. Mountford, Haase & Waller, 2006; Unoka, Tolgyes & Czobor, 2007), and much of this work has been incorporated into cognitive models of eating dysfunction (e.g. Fairburn, Cooper & Shafran, 2003; Vitousek, 1996). Anorexia nervosa is one of the few psychopathologies that can be considered ego-syntonic, in that the person either does not recognise that they have what others perceive as mental health difficulties, or if they do, they do not wish to receive treatment due to the valued nature of the symptoms (Schmidt & Treasure, 2006). Conversely, individuals with bulimia nervosa often feel guilty or angry in regard to their symptoms (Corstorphine, Waller, Ohanian & Baker, 2006; Engel, Boseck, Crosby, Wonderlich, Mitchell, Smyth et al, 2007) which would suggest that they are regarded in a different way to that in anorexia nervosa. For example, in a grounded theory analysis of letters written by patients to their anorexia, Serpell, Treasure, Teasdale and Sullivan (1999) found that the illness provided protection, control and a sense of specialness.

Previous personal clinical experience suggests that behaviours associated with anorexia nervosa may serve to provide some form of structure and meaning to life, and that the removal of these behaviours leaves the individual vulnerable to anxiety of an existential nature (i.e. life meaning and purpose). Certainly, there is some preliminary evidence to support the personal utility and value of restrictive eating behaviours. In a qualitative analysis based in phenomenological approaches and grounded theory, Nordbo, Espeset, Gulliksen, Skarderud and Holte, (2006) described several thematic constructs regarding the personal meaning of eating disorder symptoms that they identified in accounts of individuals with anorexia nervosa. All of their eight themes (anorexia as a way: to stability and security; of avoiding negative experiences; of demonstrating strength; of deriving a source of worth;

to create an identity; to elicit care; of communication; to die) indicated that the anorexic behaviour served a purpose and was therefore functional in some way. While the authors are careful to point out that the meaning derived from the symptoms by the people in the study may not have aetiological significance, understanding this meaning could provide important insights into mechanisms of subsequent development and maintenance of anorexia.

Although cultural factors are unlikely to be the sole aetiological factor in the development of eating disorders it certainly seems that within popular Western culture, the ability to retain a slim body shape has become highly valued and that individuals who can retain a thin shape may be viewed as a special minority, while the food-related practices surrounding the thin-ideal take on a significant meaning (Polivy & Herman, 2002; 2004). In this manner, anorexia nervosa may serve to provide the person with a special ability that marks them out as unique. If bulimic symptoms are the opposite of those involved in restrictive anorexia nervosa (i.e. restriction versus binging) it is possible that these would be associated with negative emotions such as guilt, despite (or perhaps because of) the role they play in self-identity (Broussard, 2005). Furthermore, a large proportion of people with anorexia nervosa later develop bulimic symptoms (Fairburn & Harrison, 2003), and it is unclear how people make sense of this shift for themselves. As such, understanding the meaning of the symptoms to the person is important in understanding how to help that person clinically.

Previous work has been conducted in this area around the relationship of anorexic cognitions to existential issues (e.g. fear of death, meaninglessness and loneliness; Fox & Leung, 2009) and personal meaning (Espindola & Blay, 2009). The latter study involved a meta-ethnographic analysis of qualitative studies published up to 2005, and identified several second and third order themes across the papers. In particular, the third order interpretation yielded two meta-categories: 'disease as identity' and 'systems of control'. The authors suggest that the first category represents the role of anorexia nervosa in

organising an individual's identity, so that their existence becomes structured around food and weight. Elimination of symptoms, therefore, becomes an elimination of the person's life. The second category represents the expressed need of people with symptoms of anorexia nervosa to control their body, feelings and the world, and the mechanisms used to fulfil this need.

Despite the previous work in people with anorexia nervosa, little research has examined the role of the symptoms in both anorexia and bulimia nervosa in the construction of personal meaning for the individual. This is particularly important given recent considerations on the 'transdiagnostic' nature of eating disorders (Fairburn, Cooper & Shafran, 2003) and an emphasis on the factors that anorexia and bulimia share rather than that which separates them (see Waller, 2008). The current research is therefore concerned with understanding the personal meaning that individuals attribute to eating disorder experiences in their life. We take a qualitative approach to answer the question: what are the individual experiences of living with an eating disorder, and how do people make sense of their experiences? The research reported in the current paper uses Interpretative Phenomenological Analysis (IPA; Smith, 1996) to consider the key themes and meanings that emerge from interviews with people who are discussing their experiences of eating disorder symptoms with a researcher. IPA appears well suited to this particular research question, in that it concerns itself with understanding the participants 'lived experience' from an idiographic level, rather than that abstracted through the notion of a generalised theory (Reid, Flowers & Larkin, 2005).

## **Method**

### *Participant and researcher information*

The participants were young women who self-reported current experiences of anorexia or bulimia nervosa, who were aged between 18 and 30, and were recruited through an

advertisement to a UK eating disorders charity (Beat). Exclusion criteria included absence of current symptoms, inaccessibility for interview (e.g. respondent resided overseas), and an age over 30 years old. 10 participants were originally recruited and interviewed, however one interview was removed due to a malfunction with the recording equipment, while another was removed due to issues regarding a potential primary diagnosis other than an eating disorder. Ethical approval was obtained from the NHS National Research Ethics Service; all participants read a study information leaflet to facilitate informed consent and discussed any concerns they had regarding the research with the first author (see Appendix 1, 2 and 3). Characteristics of the participants can be found in Table 2, along with their allocated pseudonym, while cameo outlines for each participant and their backgrounds can be found in Appendix 4.

Table 2: Participant characteristics

<b>Participant pseudonym</b>	<b>Age</b>	<b>Age of onset of eating disorder</b>	<b>‘Symptoms’</b>
Ann	24	11	Restriction, bingeing, vomiting
Beth	22	15	Restriction, over-exercise
Cathy	18	14	Restriction, bingeing, vomiting, diet-pills
Diane	18	15	Restriction, bingeing, over-exercise
Erin	18	16	Restriction, bingeing, vomiting
Fay	20	15	Restriction, bingeing, vomiting
Gina	29	24	Restriction, bingeing, laxatives, diet-pills
Helen	18	15	Restriction, over-exercise

The first author (APF) carried out this research when he was in his late twenties as part of a clinical psychology doctorate. He has not had a personal experience of eating disorders; however he has worked in the area for the past 9 years both clinically and academically. He

has an interest in existential issues in mental health, and has previously published a paper examining these issues in people with anorexia nervosa (in collaboration with the third author, NL).

### *Semi-structured interviews*

All interviews were conducted by the first author at a location negotiated with the participants that was both quiet and as private as they requested. Due to the gender of the first author, ethical approval was conditional upon investigators not being alone in the home of the participants; however, participants were dispersed across the UK. Therefore, one participant was interviewed at her parents' home (Ann), one in a quiet room at the University (Beth), four at interview rooms in their local area (Participants Cathy, Fay, Gina and Helen) and two in a café local to them (Participants Diane and Erin). Interviews were split into two parts, both conducted consecutively on the same day, the whole interview lasting between 40 and 70 minutes. In the first part of the interview, participants were encouraged to provide a narrative account of their eating disorder history, and questions were asked about the type of eating disorder currently experienced, age of onset, and duration. In the second half of the interview, participants were asked about how they understood their eating disorder, what role they thought it played in their life, and whether they had any feelings towards it (see Appendix 5). Interviews were audio-recorded and transcribed verbatim by the first author; all information that could lead to participant identification was removed or modified to retain anonymity.

### *Analysis*

The interview transcripts were analysed using the principles of interpretative phenomenological analysis (IPA; Smith, 1996). The first transcript was read and annotated by the first author (APF), general themes were noted, and a master-list of emergent themes

was developed. The next transcript was then read using the previous master-list to guide the identification of themes, and any additional themes not present were added to the master-list, and this process was repeated for all transcripts, until all the interviews had been analysed. Particular emphasis was paid to the claims, concerns and experiences of the participants, in an effort to ground the analysis in their phenomenological reality. The transcripts were then re-analysed using this final master-list, and the identified emergent themes were clustered according to shared meaning. Overarching themes were then identified that linked these clustered themes together, along with key passages of text that reflected the content of the overarching theme (see Appendix 7 for a sample of annotated text).

Analysis was facilitated through the use of a reflective group of trainee clinical psychologists who were using qualitative methods in their research and who met regularly to discuss the progress of their research and share experiences of the process. Credibility was also tested through this group, as portions of transcripts were exchanged and annotated by other members of the group, and subsequent emergent themes were developed and discussed. Any mismatches in the identified themes were resolved before coding could resume. Additionally, an experienced IPA investigator (ML) supervised the coding and analysis process for the transcripts to ensure that themes reflected the participants concerns. Minor differences were resolved at a consensus meeting.

## **Findings**

The main themes discussed in this paper, along with their super-ordinate thematic category and the participants that contributed to that theme, can be found in Table 3.



Table 3: Main themes and participants contributing to each

<b>Supertheme</b>	<b>Theme</b>	<b>Participants contributing</b>
Experience of eating disorder as functional	Sense of eating disorder as safety or back-up plan	Beth, Cathy, Diane, Helen
	Eating disorder as a distraction to cope	All participants except Erin
	Restriction providing sense of achievement and specialness	All participants except Erin
Understanding of a gradual development of the eating disorder symptoms through time	Experience of being physically different and invulnerable	Ann, Beth, Erin, Helen
	Recall of a particular 'trigger' or turning point	All participants except Ann
	Gradual worsening of symptoms	Beth, Cathy, Gina, Helen
	Sudden personal realisation of eating disorder	Beth, Cathy, Erin, Gina, Helen
	Acceptance of eating disorder as lifelong	All participants
A cycle of eating disorder symptoms	Cycling through restriction and bingeing	Ann, Cathy, Erin, Fay, Gina
	Routines and rules	Beth, Cathy, Diane, Erin, Fay, Gina
	Phases of well-being	Beth, Cathy, Erin, Gina, Helen

Table 3: Main themes and participants contributing to each (continued)

<b>Supertheme (continued)</b>	<b>Theme (continued)</b>	<b>Participants contributing (continued)</b>
The negative effects of the eating disorder	Negative impact of eating disorder upon family	All participants except Beth
	Friends not understanding	Ann, Beth, Cathy, Diane, Erin, Helen
	Unwanted physical effects of eating disorder symptoms as distressing	All participants
	Negative impact of eating disorder on achievement of life goals	Ann, Beth, Cathy, Fay, Helen
Feeling ambivalent about the experience of eating disorder symptoms	A negative punitive restrictive voice/thoughts that is disliked but is viewed as helpful in achieving dietary restraint	Ann, Beth, Cathy, Diane, Gina, Helen
	Intense dislike of bingeing	Ann, Cathy, Diane, Erin, Fay, Gina
	Experience of paradox of being in control but also controlled	Ann, Beth, Cathy, Helen
	Expression of positive feelings towards the restrictive symptoms	All participants except Ann
	Recognition of the desire to keep yet get rid of eating disorder (frustration?)	Beth, Cathy, Diane, Erin, Helen

Understanding of a gradual development of the disorder through time

This theme describes the developmental narrative that participants used to describe the onset of their eating disorder symptoms. All of the participants, apart from Ann, identified a trigger for the start of the eating disorder. These participants were able to pinpoint a particular event that, as they reflected, they felt stood out as important in explaining the onset of their disorder, for example:

Beth: "it was a comment my teacher had made to me (pause) yeah, I think that was the thing that now, I can look back and pinpoint it [the start] to that"

Gina: "someone made a comment about my size, cos I was bigger, I was probably about, I was probably about a size 12 to 14 (...) someone made a comment and that was it [pause] I got on the slimming pills (...) that's the first, that's how it started"

Erin: "[he] said: oh, you're getting a bit chubby, and that has always stuck in my mind, like, I don't remember much, I got a fairly bad memory, but that has always stuck in my mind"

Fay: "when I was 15 my [relative] died and someone I was very close to was diagnosed with breast cancer, and, um, I just started restricting"

Ann explained that she believed that her own experiences of the development of eating disorder were closely linked to obsessive-compulsive tendencies that she had from being a small child, and did not identify a particular trigger. However, she did discuss how she felt she had a need for 'control' in her life that she associated with some form of personal trait, for example:

Ann: "I felt out of control, I felt that the world was a scary place that needed, I needed to put somehow, put some control into and at that very early age I realised that [pause] obviously the first thing that came to me was my body"

She was also the only participant with whom the first author had any prior relationship, as she had attended a residential centre where he had worked before starting his training in clinical psychology. This may have influenced the nature of the interview in different ways to

the other participants, and time was spent around and during the interview in catching up on recent experiences, including those regarding the eating disorders service where both had spent time.

Several participants spoke about a gradual worsening of eating disorder symptoms following the initial onset, although they believed that they remained 'in denial' through this progression:

Helen: "the lunch went in the bin, I started to say I'm not eating that, and then breakfast went straight in the bin, and then I'd stay out, I'd stay at friends, it just escalated [pause] I thought everything was fine, then months went on and I felt myself getting ill but I just denied it"

Beth: "I think when it first started I didn't really realise it was happening, erm, I think I sort of cut down on food, cos I was about 15 when I first got ill, erm [pause] and obviously, I don't really remember it, like people or some people I've met from treatment along the way say they had, you know, woke up one morning and like they felt fat and they had to go on a diet, but I've never had that moment (...) it was sort of a more gradual process"

Linked to this gradual progression, five of the participants indicated that this seems to have culminated in a sudden realisation that something was awry, often through the reactions of other people. For example:

Cathy: "Erm, well at first I was like everything's fine - and it's not – but then I ended up on a drip and then I saw my mum and she was devastated and I was like, ok, this isn't normal"

Helen: "I realised something's weird, and when I was taken backwards and forwards to hospital, I just thought, what am I doing?"

Erin: "when my sister saw me just before the summer, she was like, 'you've lost loads of weight, what's going on?', and then suddenly it was like a really big thing, from like very suddenly everyone getting at me, like, you've lost loads of weight, and then I guess I kind of realised, and I saw pictures of myself when I was at Europe on holiday and I was like, woah!"

These reactions seemed to upset the participants who experienced them, and the emotional reaction appeared to trigger the start of a reflective process regarding the eating disorder. All of the participants expressed what appeared to be a type of resignation, seemingly associated with their belief that their experiences of eating difficulties would be life-long:

Fay: "I've sort of come to realise that I either come to live with it or [pause] I'll die, basically. I can't, you know, there isn't - I've tried very very hard to get rid of it, and I really really wanted to and I have never managed to be able to, so I just have to learn to accept it"

Helen: "I don't think it's ever going to go away, I think it's always going to be there"

This particular theme appears to demonstrate a potential point at which the participants may have become 'stuck' in the development of their eating disorder and potential recovery. All but two of the participants (Diane and Erin) appeared keen to explain that although they had at various times struggled to give up their eating disorder, they believed that they had been unable to rid themselves of it completely, and now felt resigned to a life that in some

way incorporated the symptoms. Considering Diane and Erin, the start of their experiences was somewhat more recent than the other participants (around 2 years), and it is possible that this influenced their contribution to this theme. It may be that the resignation expressed by the other participants was a result of the length of time spent struggling with their eating disorder, something which would potentially support the notion of early identification and engagement in services of people with eating disorders – before they begin to feel more hopeless.

### A cycle of eating disorder symptoms

Following on from the development of eating difficulties, participants also discussed how their experiences appeared to fluctuate, and cycle through different states. Several participants described how they saw different symptoms as associated with each other, particularly the bingeing and purging, although this was only found in accounts of people who described dietary restraint as well as excess (e.g. restriction, bingeing, vomiting, laxative abuse etc). For example:

Fay: “restricting generally revolves around limiting my calorie intake and basically feeling fat, and I’m very, very, very limited as to what I will actually eat, which is probably only about 4 or 5 things, and then I’ll drink a couple of types of drink, but that’s it really [pause] and then the bingeing and vomiting kicks in and I would never eat any of the things I eat if I wasn’t out of, completely out of control, and then I purge them”

Cathy: “I like, restrict myself, from like absolutely nothing - my body’s like, ‘God, I need food!’, and then I’ll have something, like a little, like a meal, so I’ll eat a meal and because I haven’t eaten like, for say, 2 weeks, and then I have a meal, in my eyes that’s like a binge”

In this way, the participants described how one set of behaviours (e.g. restriction) led them to into another set of different but related eating-disorder behaviours (e.g. bingeing) and subsequently further behaviours (e.g. purging). Cathy, for example, explained how her knowledge of being able to vomit allowed her to legitimise any impending binge:

Cathy: "I just ate crisps and chocolate, and stuff like that quite a lot, um, and my mum was like, my mum was like 'are you sure you wanna eat that?' and I was like, 'I'm fine, I'm fine', erm, but in my head while I was eating it I knew I was like, I was gonna make myself sick after this, I just knew, so then I thought, screw it, I'll just eat whatever I want"

Similarly, Ann described her 'discovery' of vomiting as like an epiphany:

Ann: "[I thought] I have to get rid of these peas, I have to get rid of them, or I'm going to become fat, so afterwards I went to the toilet and I puked, and it gave me a sense of control, it's like, ta-da! I can eat anything and I can puke!"

Many participants also discussed their perception of particular rules or routines that they had for themselves in regard to their eating behaviour, and how these were linked into the different types of eating behaviours:

Erin: "when I don't stick to my routine, that's when I panic a bit, like it's ok if I planned it, like I really like cooking, so [for example] I'm cooking a dessert, I'm gonna have that, then it goes a bit crazy and I've had two portions, then it'll be like, 'oh dear!' and that's when I will probably make myself sick"

Gina: “[after purging] I know that it’s going, it’s gone, it makes me feel better about the whole situation, I don’t feel 100% after it, but I think, well, that’s gone now, I’ve shifted that, that foods gone inside me, but now I’ve got rid of it, so now I feel, I feel 90%”

It seems as though these rules and routines went some way towards governing the form that the eating disorder took, as the behaviours would often be based upon keeping to (or breaking) these implicit codes of conduct. Although bingeing was often seen as ‘giving in’ to physical urges and breaking the implicit rule of restriction, purging was understood as a way of limiting the impact of breaking this rule.

Some participants also described their experience of the severity of the eating disorder as fluctuating, as they experienced phases of the eating disorder where it became a more or less problematic part of their lives:

Cathy: “and I think when I went through the period of 6 months when I was ok, those [anorexic] thoughts were dying, I didn’t have them as much and that’s when I thought, like, oh, things are picking up a bit. But then something came back”

Gina: “before I fell pregnant, I was, um, a very low weight, er, through restricting and diet pills, then I fell pregnant, nobody knows how but I did, yeah, and um, cured, I was, throughout my pregnancy I was, I was fine”

Diane: “for example, if I were surrounded by family, like, if I were to go on holiday or something like that, and there was none of my friends or anyone else was going around, and then it kind of disappears for a bit [pause] because I don’t feel as though I need to make an effort”



Such descriptions suggest that the experience of eating disorder symptoms is not static, and that it can vary in relation to other environmental factors and life-events. This appears to contrast somewhat with the earlier theme of the eating disorder as an inevitable lifelong (and therefore somewhat stable) companion. There also appears to be a relationship between the previous theme of a trigger to the onset of the eating disorder, and the situations in which the participants experienced variation in their eating disorder. In the above quotes, both Gina and Diane are referring to situations in which social appraisal could be an important factor in the stability of the eating disorder over time – for Gina, being pregnant seems to have allowed her to relax her eating disorder, while for Diane, the same was true while she was absent from the critical appraisal of her friends. Similar situations (i.e. those that involve anticipated social evaluation or approval) also seemed to be important in understanding the earlier theme of an eating disorder ‘trigger’.

#### Experience of the eating disorder as functional

For all the participants, there appeared to be a theme regarding the functional role that the eating disorder played in their lives. In particular, it was identified as an explicit strategy deployed to help distract attention away from unpleasant experiences onto something considered more manageable, for example:

Cathy: “when I was concentrating about eating I wasn’t thinking about anything else but my eating, it blocked my mind off everything else that I didn’t want to think about”

It seems as though by focussing on food and eating, participants were able to distract themselves from other troubling experiences. Indeed, closely related to this, is the

experience that the eating disorder served as a 'back-up plan' or 'safety net', in case events in life got out of control:

Beth: "at least by having these thoughts and compulsions in your head, you know where you're at [pause] you know that's always your back-up plan if everything else goes wrong"

In this way, participants suggested that they thought the eating disorder was useful as a technique in their repertoire that they could use to cope with the difficulties of life, and that being aware of this was in some way comforting. Participants also explained that they were afraid to give up their eating disorder, for fear of the unknown situations and feelings that they would potentially face as a result:

Helen: "this is safe because it's familiar, I know how I feel, there's no emotions that I don't know that I have that are there"

Most participants also explained that they believed the restrictive components of their eating disorder provided them with a goal or achievement that they could feel special about. For example:

Fay: "it gives you something to aim for, it's the only thing I've ever done that makes me feel like I'm good at something, so that's what I've done"

Cathy: "someone said to me 'do you not see achieving exams, like getting good exam results - that's an achievement?', and I'm like, my head doesn't see that as achievement, and it just sees that as like normal, everyone achieves that, I wanna achieve something different and losing weight and stuff in my eyes is an achievement"

In Cathy's quote, it appears that she believes that for her, losing weight is an achievement above and beyond 'normal' standards, such as the achievements her peers may gain through their exams. Indeed, it seems that for many of the participants, losing weight was an achievement that served to mark them out as particularly special. Closely linked to this theme was the expression of the belief among participants that somehow they were different to others or invincible from the effects of extreme dietary restriction or frequent bingeing-purging. Participants recognised this belief in themselves and in others:

Beth: "I think a lot of people think that, they, with anorexia, they think that they're kind of invincible, cos you can push yourself really far and to a certain extent you can, because [pause] there's not really that many people that can starve themselves to the point of death"

Erin: "I know that the effects are like wrong, and it's like really bad for your throat and it's really bad for your stomach, and yeah, it's bad for your health, like, if you're anorexic it's bad for your bones, like it causes long-term problems, like if you're underweight for a significant amount of time, but then it's like, I don't know, I know that, but I don't think that it relates to me or that I don't believe it"

In Erin's quote above, there appears to be recognition of the negative long-term health implications of her actions, but also a reluctance to engage with this recognition. This has echoes of previous research investigating the attitude taken by ecstasy users towards their use of the drug – they knew it could potentially do them some harm, but they were reluctant to engage with this knowledge (Larkin & Griffiths, 2004).

Overall, this theme seems to suggest that in one way or another, the eating disorder, but particularly the restrictive elements of it, appeared to serve a functional purpose for participants – either as a distraction from distressing events, or as a signifier that they were different, special or unique. In this sense, the eating disorder appeared to have positive personal salience for the participants.

### The negative effects of the eating disorder

Following on from the functional aspects of eating disorders, participants also described the negative effects of their eating disorder. All of the participants, with the exception of Beth, explained how they believed the eating disorder had been a negative influence on their family. For example:

Cathy: “yeah and it ruins my family, really, cos they’re like, worried, they don’t understand, so it causes so many arguments in the house, and then I’ve got two brothers and then they worry, and then I’m like, look at me, I’m just ruining everyone”

Fay: “I dislike what it’s done to my parents and my family, just the amount of worry and stress, and just the way it hurts them, and I hurt them, and, yeah, I hate it, I hate it for doing that”

Helen: “it also effects your family drastically, like I made my mum ill, made my dad ill, my brother’s ill as a result”

Smith and Osborn (2007) outline how sufferers of chronic back pain also struggled with the effects of their experiences upon important relationships in their lives. In particular, participants in the study appeared to struggle with the negative, unwanted self that was

constructed in response to the pain, and how this had a negative impact on their relationships with others (Smith & Osborn, 2007). There appears to be a similar process expressed in the previous quotes, especially when taken in the context of the subsequent theme of ambivalence towards the disorder. Participants appear to be struggling with the negative impact upon others of the self that they construct through the eating disorder. A clue to this struggle may be found in the switches between the third-person (e.g. 'it hurts them') and first-person (e.g. 'I hurt them') in all of the above quotes.

Beth made very little mention of her family throughout the interview, so her absence in contributing to this theme may be a reflection of this general tendency. Although there is the potential that there may be some other reason why she was a notable exception in contributing to this theme, it is impossible to tell from the data why this may be. She did, however, mention her friends and how she struggled with her perception of their reactions to her eating disorder. Indeed, all of the participants were younger (i.e. under 30 years old) and the majority of them made reference to difficulties with their peer-groups, which is perhaps not surprising given the importance of friends at this developmental stage:

Beth: "[physical illness] is more acceptable than, like, 'I've got a mental illness, I starve myself', and then the thing of people don't understand, and they think you're selfish for not eating and how can you put this hurt onto everybody else, and you're like, 'well, I don't particularly want to do it, I don't like doing it, I just, that's the way it is', which is a really hard point to try to kind of explain to somebody"

Cathy: "friends, they kind of give – not give up, but I know it must be hard for them to understand cos I'm so up and down all the time with my eating"

Participants explained that they felt that their friends did not understand what they were going through, and they felt somewhat alone and abandoned by their friends. Cathy described how she had a friend who had some experiences that had offered her some insight:

Cathy: “and I’ve got one friend who’s, well, she suffers with ME, and so she can understand being depressed and stuff like that and so, she’s always like, I know I can’t understand like the bulimia, but I can understand the feeling low and stuff, so she tries to relate to, like hers to mine”

Three participants described how they also felt distressed regarding some of the negative physical consequences of the eating disorder upon their bodies. Although there were desirable effects of behaviours such as dietary restriction, as seen in the previous theme, these were also associated with unwanted aspects as well:

Diane: “up until then, I don’t think I saw it as anything, any difficulties or anything like that because it was fine and I didn’t feel any different [pause] then, um, I started getting quite ill, I had, like, five chest infections and, and my hair was all falling out and I was really moody in general”

Several participants also emphasised how they believed that the eating disorder had taken away time of their life that they would never regain, and that they felt resentful towards it for this:

Ann: “I literally for me, I feel, that I have a black hole, I feel very ashamed because of the fact that I haven’t been through school and University, and I don’t mind saying I know that I’m bright, and I come to this point at age 24, where I’m

like I want to do things but because of the society we live in – where's your CV, where's your GCSE's?"

Beth: "yeah [pause] sometimes I really hate not being normal or, saying, not, not doing like, erm, what other people may age have done, like, say I'm 22, most of my friends have already graduated and stuff, and I've had to go back to college to get my A-levels, and I think, 'why?', cos at the end of the day, I didn't get very far with it and think [pause] however much weight you lose, you end up getting put back in hospital to gain it all back again"

Helen: "it stops everything, it puts a hold on your life, literally, physically, mentally, socially – my dancing's, all the things I loved stopped, I wanted to go skiing, I wanted to do PE, that stopped, I couldn't get any clothes"

This sense of loss appeared to have motivated Ann, Cathy, Helen, and to a lesser extent, Beth, to take control back from their eating disorder and achieve the goals they had in their lives. For example:

Helen: "and that's my goal, and I want to have kids, so [pause] I know to maximise my chances I have to keep doing what I'm supposed to do, whether I like it or not, whether I hate every minute of it, but I have to think of my future"

### Feeling ambivalent about the experiences of eating disorder symptoms

Many of the participants' descriptions of their eating disorder seemed to reflect recognition of feelings of ambivalence towards their experiences. On the one hand there were aspects that participants quite liked about their eating disorder, but on the other there were aspects they seemed desperate to get rid of. Several participants made reference to a powerful

anorexic 'voice', which they recognised as internally generated, but yet felt slightly distanced from:

Gina: "she'll [the voice] say 'just have a drink because if you have a drink you won't eat, and you can't afford to eat because you're awful enough as it is, don't put yourself through this, you need to be slimmer, you need to be more attractive, you need to get to a certain weight', when I get on the scales, if I see the wrong number, she's like, 'well, that'll teach you'"

Cathy: "if I am eating it's like, 'should you really be doing that?' and 'don't do that, you're just going to have to make yourself sick', and all that kind of thing"

Although the voice was commanding and punitive, that often had negative effects on their mood, participants expressed a desire to keep the voice, as it helped them achieve dietary restraint. In particular, Gina felt that the voice was an important experience of her eating disorder:

Gina: "I feel that she's gonna make me [pause] look how I wanna look"

I: "ok, so she's useful"

Gina: "she's helping me, um, she's stopping me, you know, and it's like with the bingeing as well [pause] I also, she comes into play then [pause] you know, she's like 'you can't binge' and I'm like 'no, no, I can't binge'...she helps me restrict, this last, yeah, month or so, she's really helped, you know, stop that bingeing"

Indeed, all participants apart from Ann expressed positive feelings towards the restrictive elements of their eating disorder, despite some of the negative consequences of such extreme dietary restriction:



Fay: "I'm much more productive and I function much better when I'm starving"

Helen: "for a part of me it's [restriction] still safe, and then it's the control again, I just know how it feels, it's familiar, and I can deal with myself"

Dietary restriction appeared to serve as a goal that participants felt safe and comfortable with, and that made them feel at least partly good about themselves. In this way, participants seemed reluctant to eliminate this component of their lives. Related to this theme was the expression of bingeing as a negative experience that was intensely disliked:

Fay: "I dislike the bingeing and the purging"

Gina: "I hate it, no, I don't agree with it, no I don't know why I did it, and it's times like this that I think, if I hated it that much, why did I do it?"

Given that different symptoms are related to differently in this way, it is perhaps not surprising that several participants expressed frustration over their conflicting wishes to both keep and yet get rid of the eating disorder. For example:

Beth: "some days I kind of wake up and I'm so exhausted and I think 'oh no, not this again', you know, and then other days it wouldn't bother me at all, cos I'd just know that it's a part of me, I don't see it as separate any more and it doesn't really bother me what I can and can't eat, but then other days, like say, if I want to go out with friends or something, and I have to constantly, they're just like, 'oh yeah, let's go' and that's it, and I have to constantly worry about 'oh my God, can I afford to eat that slice of pizza?' and it's like 'shut up – I don't want to be listening to this, I just want to go out', erm, so yeah, in that sense, it gets a bit tiring, erm, and then sometimes I'm able to say to myself it doesn't matter that I

can just go out and whatever, erm, and then other times I will turn around and say 'no, I can't go out', and you've got that frustration that you want to go out but you know that there's no point because you'll feel so crap afterwards"

Diane: "my head is telling me yes, you shouldn't have it, because I miss not thinking about food and I miss not caring about anything and having fun...but at the same time, I'm scared as to what would happen if I didn't think about it all the time because I don't remember what it felt [pause] and if I were to let myself go, er, I don't know what would happen"

Several participants also talked about a type of paradox, where they felt controlled by their eating disorder, but somehow also in more control of their life:

Beth: "you're very much torn in two, that sometimes it feels like you need it there to make you feel safe and so that you feel in control of something, that you're in control of what you eat, and how it's like a paradox because you think you're in control but you've got absolutely no control at all because the voice is controlling you"

Cathy: "even though I feel like, even though it's like part of me I haven't got control over, I have still got control over it, I know it's coming back to control, but losing control, like having nothing to achieve, like if I do, oh in a week I lost a few pounds, I've got that achievement, and I'm achieving something - with everything else I don't see it as achieving"

This theme seemed to link back to that regarding the functional role of the eating disorder, as can be seen in Cathy's quote above. Although participants were able to recognise that more often than not they would be considered 'high achievers' at school or in work (several

went to exclusive public schools), nothing seemed able to match the sense of achievement gained through dietary restriction. Despite this, however, Ann appeared to feel quite negative towards many aspects of her eating disorder, which perhaps set her apart from all the other participants, who generally expressed a mixture of positive and negative feelings towards it, as reflected in this theme. It seems possible that Ann was in a slightly more advanced stage of recovery from the disorder than the majority of the other participants, which may explain her reduced contribution to this theme.

## **Summary of findings and discussion**

It appears that one of the main themes within the accounts of the participants is that of ambivalence towards their eating disorder. On the one hand participants were able to identify many things they disliked about their eating disorder symptoms, and many negative effects that it has upon both themselves (e.g. their bodies) and others (e.g. friends and family). However, it also seems that the disorder offers them something that they find functional, which although is idiosyncratically unique for each particular participant, is also something that has shared aspects.

The sense that the eating disorder provided some form of specialness would fit with the developmental context that individuals involved in the study are likely to be engaged with. The social-cognitive concept of adolescent egocentrism (Lapsley, 1993; Vartanian, 2000) suggests that adolescents tend to think of themselves as particularly unique or special, and that this tendency wanes as they gain more social experience and realise that they are neither particularly unique nor special. The participants in the current study were aged between 18 and 29, and there is some evidence that young adults experience an increase of egocentricity around this age (Frankenburger, 2000). However, there is also evidence to suggest that individuals who experience mental health disruptions during this period also show concurrent exaggerated adolescent egocentricity - more so than normative adolescent

populations (Fox, Harrop, Trower & Leung, 2009; Harrop & Trower, 2003). As such, eating disorder experiences could be providing a sense of specialness that is related to adolescent developmental processes, and once the particular tasks of this stage of development are negotiated (e.g. separation-individuation, autonomy, social networking etc) this sense of specialness may reduce. In which case, encouraging people to engage with these 'tasks' may help them to reduce their reliance on eating disorder symptoms as a source of specialness, for example, by engaging with their peer group or spending time involved in occupational activities such as work, school or a hobby.

The sense of specialness and achievement reflected in the accounts of the participants could also serve as some form of defence against the recognition of existential issues. Yalom (1980) suggests that engagement with the belief that one is special or somehow different to others can be a powerful form of death denial. This is particularly striking in participants accounts of their rigid belief in their invulnerability, despite being in some cases morbidly underweight. As previously mentioned, there have been links made between adolescent development and invulnerability beliefs in the literature via the concept of adolescent egocentricity (Vartanian, 2000); however, it is also possible that this belief has existential salience for individuals. The belief that one is somehow different or unique allows a person to avoid accepting the distressing realisation of death and the responsibility of ones own actions that result from this (Yalom, 1980). If eating disorders engender a sense of uniqueness, as suggested in the current participants' accounts, then they may play a very functional role in defending against existential anxiety (loneliness, meaningless, fear of death). Although eating disorders may not develop out of an explicit attempt to deal with such issues, it is apparent from the present research that they may subsequently take on such a role within a person's life, in which case successful recovery from an eating disorder would also require some form of resolution of these existential issues. Indeed, many participants explained that they saw their eating disorder as distressing and yet comfortable – they knew where they stood in relation to it, and could predict their lives through it. This

appears to be related to the theme that reflected the paradox of being controlled yet in control of the eating disorder – although the eating disorder takes control of the participants life, their life becomes much more manageable, predictable and therefore ‘safe’. The eating disorder, through strictly controlling what they do with their lives, offers participants a sense that everything is much more ordered and controlled, even if it is on the eating disorders terms, rather than their own.

From participant's accounts, there also seemed to be a division between those participants who saw the restrictive elements of the eating disorder as aspirational and those who saw them as more achievable. Again, this appears to link back to the belief that dietary restriction is, on balance, a laudable goal that provides a sense of achievement and specialness. Within the area of eating disorders there has long been the sense of a ‘split’ between individuals who successfully achieve the lofty goal of dietary restriction (i.e. maintain a BMI of less than 17, and are therefore diagnosed with anorexia nervosa) and those who do not (those with a BMI above 17, and are therefore classified as bulimic or ‘eating disorder not otherwise specified’). Within participant's accounts, several spoke of wishing to retain the restrictive elements of their eating disorder, while jettisoning the bulimic components, so that they could attain their desired goal of a low weight.

I: “So, what would you say to the restrictive bits?”

Cathy: “Stay”

I: “And how would you say it? What would you say?”

Cathy: “I’d want it to stay and to be more, just, more like determined and, um, to be, like – this sounds really bad – but to be more selfish and don’t give in to other people, erm, and just, I mean, it’s what I want to do, so [pause] do it for me and if it upsets everyone else then just ignore it”

At this point, Cathy was explaining how she would be happy to get rid of the bulimic components of her disorder, but wanted to empower the restrictive components, despite the negative impact on others. This could be seen as a difference between participants – some were satisfied with their ability to restrict their diet (e.g. Beth, Gina and Helen) while others expressed a wish that they could become more effective at restricting. Again, this seems to reflect the level of specialness that restrictive experiences are imbued with. Previous research suggests that Western culture places an unhealthy emphasis on the ability of women to obtain an unrealistic body-shape (Polivy & Herman, 2004), such that those who can obtain the culturally endorsed shape are considered more successful. Indeed, there is the notion of the pathoplastic effect of Western culture: as Western culture permeates a society, incidences of eating disorders increase (Russell, 1995).

In the previous excerpt, Cathy alludes to the eating disorder potentially upsetting other people. Indeed, family issues were discussed by many of the participants as a major source of personal and interpersonal distress, as reflected in the theme regarding the negative impact of the eating disorder. Among current treatments recommended for anorexia nervosa are family-based interventions (NICE, 2004), as it has long been recognised that families play an important role in the lives of people with an eating disorder (e.g. Minuchin, Rosman & Baker, 1978). However, participants also spoke of the social isolation they experienced through their eating disorder, and there has been comparatively little research conducted on this aspect of social relationships. This is somewhat surprising given that eating disorders typically (but not always) develop during the teenage years (Fairburn & Harrison, 2003), which are associated with increased peer-group socialisation and experimentation with potential romantic relationships. If, as suggested by participants in the current research, eating disorders are associated with the experience of becoming isolated from friends, it may be that interventions could focus on encouraging young people with eating disorders to experiment with re-engaging their peer-group community in an effort to develop potentially helpful relationships with others. Furthermore, as already mentioned,

this may offer a source of personal meaning or achievement beyond that offered by the specialness of dietary restriction that seems so salient in the experience of eating disorders in the current participants. However, care would need to be taken with such an approach, as several of the participants identified peers as a possible source of conflict and distress in their lives, as reflected in the social-evaluative content of the themes about a trigger and the development of the disorder over time.

In participant's accounts, there appears to be a reproduction of a medical discourse, in that they discuss their 'disorder' as being a lifelong condition, with symptoms that they will have to cope with (e.g. "I don't think it's ever going to go away, I think it's always going to be there"; Helen). Participants also appeared to be comfortable when talking about different 'symptoms', for example in Fay's account of her 'restricting' and how the "binging and vomiting kicks in". This seems to situate eating difficulties as discrete (disease) entities that exist and have to be managed, perhaps through medical professionals. It may be that this way of conceptualising the experiences is helpful, as it helps to separate them from the person, particularly if they are painful and aversive experiences. Indeed, one approach often used to help people with eating difficulties, typically in narrative therapy, is to conceptualise difficult eating experiences as a 'thing' that is separate to the person (see also Dallos, 2004). However, by doing this, there may be an implicit unintended endorsement of a diagnostic model to understanding eating difficulties, and this model, particularly in the eating disorders, is not without its critics. Indeed, there have been suggestions of a move away from current classifications of anorexia and bulimia to other, perhaps more flexible understandings of general eating distress, such as Fairburn's 'transdiagnostic' model (Fairburn, Cooper and Shafran, 2003) or a general anxiety-based system (Waller, 2008; see also Strober, Freeman, Lampert & Diamond, 2007). Furthermore, the idea of a disease process may reduce the amount of power someone feels they have over their ability to change their current experiences or situation. It is possible that

alternative methods of conceptualising distress, such as through formulation, may offer more hope or motivation for potential change.

As a researcher, it was not hard to engage with participant's accounts of their experiences as disease-processes, as for them it seemed to be their phenomenological reality. Indeed, this is reflected in the titles of some of the super-themes (e.g. 'Cycle of eating disorder symptoms'). However, this does not necessarily make it a particularly helpful way of understanding their difficulties. Indeed, as a clinician, the first author works primarily outside of the realm of medical diagnoses, even to the point of actively avoiding them, partly due to the stigma that that can be associated with them (e.g. 'schizophrenia'; Knight, Wykes & Hayward, 2003). However, in the current accounts, it seems that there may be something to be gained by using the medical discourse of diagnoses, as participants indicated that there were aspects of their experiences that made them feel special. Perhaps this is the opposite of stigma? That people feel the attainment of a diagnosis such as 'anorexia' marks them out, not as different in a bad way, but as different in a good and desirable way – which would appear to link back to the effects of 'pathoplastic' cultural norms. Those that can achieve thinness, as represented by the 'badge' of anorexia, have achieved something considered worthy of envy from others. Therefore, as a clinician and a researcher, it seems that care needs to be taken in potentially reproducing or reinforcing unhelpful cultural beliefs; indeed, the language of medical diagnosis fills this paper. However, in the current context of this paper, this represents a grounding in what appears to be participants reality, and should not be taken as an implicit endorsement of this way of conceptualising psychological distress.

It also appears as though this endorsement of a medical narrative provided paradoxes in participant's accounts, particularly when considering the nature of the eating difficulties. For example, participants appeared to discuss how they sometimes understood their experiences as a lifelong disorder (e.g. "I just to have to learn to accept it"; Fay) but also



that they were a reflection of something they were responsible for (e.g. “just the way it hurts them, and I hurt them”; Fay). In this way the eating difficulties appeared to represent both an objectified disorder separate to the participants, but also a manifestation of a component of themselves. This appears to echo the paradox of control under the identified theme of ‘ambivalence towards the difficulties’, in that participants felt in control of and yet controlled by their eating in a similar way to them being separate and yet part of them. It seems that although externalisation may help to distance people from the negative effects of their eating difficulties, it also distances them from the perceived positives. It may be that the apparent paradoxes in participants accounts are a reflection of the desire to keep some of the effects of the eating difficulties (e.g. thinness, sense of control) while rejecting others (e.g. family tension, physical ill-health). As such, when working with people with eating difficulties, it may be that an awareness of these paradoxes could be helpful in understanding their experiences and some of the ambivalence that seems to be reflected in the accounts described in the current paper.

The current research has attempted to use IPA to increase the knowledge of the personal experiences and meaning attributed to eating disorders. This approach is necessarily a method that involves the researcher developing their own understanding of the participant's expression of their experiences and the meaning they make from them. Therefore, the generalisability of the findings beyond the participants and researcher involved in the current study are limited. However, having worked in the area of eating disorders for several years (see Method) it is the first authors' opinion that many of the themes identified in this research can be observed in clinical work with people with eating disorders. Indeed, it was particularly difficult for the first author to listen to some of the accounts of hopelessness for the future expressed by participants and to remain in the role of a researcher (i.e. to not intervene with a clinical suggestion, motivational reflection or observation). Reflecting on the interviews as they were transcribed, there was a feeling of sadness that many of the participants appeared to feel little hope for a life free from their eating disorder. There is a

potential that this feeling of hopelessness could be mirrored in clinicians working with people with eating disorders (e.g. through transference processes) which may negatively impact on the ability to effectively engender an attitude of hope for the future of clients.

A possible limitation of the current research is the use of a relatively heterogeneous sample of eating disorder participants. Previous research has involved people with either bulimic or anorexic tendencies, while the current research was designed to offer an account of people's experiences of general eating disorder symptoms. However, 'eating disorder not otherwise' specified is the biggest diagnostic category for eating disorders (Fairburn & Harrison, 2003), comprising people with a range of eating disorder symptoms who do not meet the diagnostic criteria for either anorexia or bulimia nervosa. In this context, the current research has attempted to examine some of the themes that eating disorders have in common across the sub-categories (e.g. experiences of the development of the disorder), as well as some of the themes that may be linked to particular symptom patterns (e.g. distress associated with bingeing). Indeed, the current research has emphasised the related and cyclical nature of eating disorder symptoms, and how individuals' experiences of the eating disorder vary over time and are shaped by life events. Future work could examine the similarities and differences between different eating disorder experiences, perhaps through the use of separate groups of individuals with discrete eating disorder symptoms. A comparative study that uses IPA in this way could explore some of the experiences of eating disorders illuminated in this study.

It was also apparent from the current research that different participants appeared to be at different places in the way that they related to their eating disorder. Ann expressed how angry she was that she had lost so much of her life to her eating disorder, and appeared to be very much in favour of eliminating the disorder from her life completely:

Ann: "I think I have quite a lot of bitterness towards it, I think it's taken away, for me, it's taken away my childhood - well it did basically - it's taken away the [pause] so I'd be angry at it, I'd say you've taken away my chance to go to school, University, to have friends, um, but I also then come back to' you've taken that away but I'm not going to let you, I'm not going to let you rule again"

Other participants were more fluid in their feelings towards the disorder, as expressed in the theme of ambivalence, and it may be useful for future work to interview people with similar perspectives on where they currently stand in relation to their eating disorder (e.g. in recovery etc). It may be that there are particular themes relevant to people who take different perspectives on their disorder that were not identified in the current study, and such themes may prove useful for clinicians working with people across the spectrum of eating disorders.

Another important consideration regarding the current research is the relationship between the participants and the researcher. Due to the first author being male and the participants being female and potentially from vulnerable backgrounds, there was an ethical stipulation that at no point must both parties be left alone together in private areas (e.g. at participants home). Although this was never explicitly discussed, interviews were quite obviously carried out in relatively public areas, which may have influenced the dynamic between the researcher and the participant. Indeed, in two cases, participants were interviewed in cafés, (at the participants request), meaning that they were far from private, especially considering the nature of the material discussed. Had the researcher been female, there may not have been such an explicit concern regarding private meetings, but also the nature of the relationship - and subsequently the information explored in the interviews - would have been different.

In conclusion, the current research expands our knowledge of young women's experiences of living with eating disorders, and the meaning that they derive from these experiences. Among these, it seems that eating disorders can play an important role in providing a sense of achievement for people, despite the negative consequences associated with many eating disordered practices (e.g. restriction, bingeing). Furthermore, although individuals were able to identify and discuss negative consequences, such as the impact upon family members and the distressing physical impact of the disorder, they also expressed a level of ambivalence towards their experiences, and many seemed reluctant to give up the disorder. Such experiences may shed some light on the low recovery rates for eating disorders, particularly anorexia nervosa, as it seems that restrictive symptoms have a powerful personal salience for some individuals (see also: Slade, 1982). Given the cultural climate of the thin-ideal, it is perhaps not surprising that for some people, losing weight can become one of their ultimate life goals – a physical marker of an ultimate achievement. When working with people with eating disorder experiences, it may be that by taking into account the personal meaning of eating disorder symptoms clinicians can work collaboratively with service-users to move towards more recovery-oriented approaches. Clinicians can then incorporate an understanding of the role of the eating disorder experiences in a persons' life into their work, and support them to explore other areas and make the changes they wish to make in an effort to improve the quality of their lives.

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## **List of Appendices for Volume I**

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## Appendix 1: Letter of ethical approval

R&D Unit, BSMHT  
Radclyffe House  
66/68 Hagley Road  
Edgbaston  
Birmingham  
B16 8PF

Tel: 0121 678 4326  
Fax: 0121 678 4319

Dr Andrew Fox  
Trainee Clinical Psychologist

28 May 2008

Dear Dr Fox

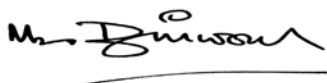
**Re: “The personal meaning of eating disorder symptoms”**

Thank you for returning your completed Trust Research Application Form for the above project. This research was approved by the Director of Research & Development and we have received notification of a favourable ethical opinion. You may therefore commence the work.

Please note that the Trust’s approval of this research is given on the understanding that you are aware of and will fulfil your responsibilities under the Department of Health’s *Research Governance Framework for Health and Social Care*, including complying with any monitoring/auditing of research undertaken by the Research & Development Unit.

Please do not hesitate in contacting the Research & Development Unit should you require any advice or support on any aspect of your project. When contacting us it would be helpful to quote our reference number for this project: **NRR 891**.

Yours sincerely



Max Birchwood  
Director of Research and Development

## Appendix 2: Participant information sheet



### **The personal meaning of eating disorder symptoms**

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

### **What is the purpose of the study?**

Eating disorders are among the most resistant of mental health problems, but little is known about why they are so difficult to treat. Some people have suggested that it is because certain aspects of eating disorders may be perceived as quite positive.

However, very little is known about the experiences of people with an eating disorder and as psychologists, we'd like to know more.

### **Why have I been invited?**

We are asking women aged 18-30 who are currently experiencing either anorexia nervosa or bulimia nervosa to take part in two short interviews to help us understand the different experiences that are important in the lives of people with eating disorders.

### **Do I have to take part?**

It is up to you to decide. Read through this information sheet, and if you think you would like to talk to us, then you may ring us at the number at the bottom of this sheet to arrange a time to meet. When we meet, we will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

### **What will happen to me if I take part?**

We shall arrange a time to meet for two 90-minute interviews. The interviews will cover a whole range of topics that you'll most likely be quite familiar with, and also some that you might not be. This includes questions about behaviour (such as eating or sleeping), and questions about thoughts (such as beliefs you may have about yourself). We are particularly interested in your attitudes towards eating disorders. We will record the interviews onto tape so that we can transcribe it into text – this will help us analyse the information.

### **What will I have to do?**

If you would like to help us in our research and share your experiences of an eating disorder, then please contact us at our address, telephone number or e-mail and leave your contact details, or complete the slip at the end of this leaflet. We will then contact you to give you a chance to ask any questions you might have before you agree to take part. We regret that travel expenses cannot be paid, but will aim to organise a mutually convenient place to meet for the interviews.

We've included some useful help-lines and contact numbers at the end of this leaflet for anyone who may be feeling upset or distressed. Many of these are also useful if you're having problems unrelated to our research. *We cannot promise the study will help you but the information we get from this study will help improve the treatment of people with eating disorders.*

### **What if I don't want to carry on with the study?**

You may withdraw from the study at any point during the interviews and for any reason. Once the interviews are complete, you may ask to have your data destroyed for up to 2 weeks after the last interview.

We keep a transcript of the interview for 5 years in locked cabinets at the School of Psychology in Birmingham University in case there should be any query over the data. All the data are confidential (we store the consent form separately from the interview data), and all quotes used from the study will be allocated to a pseudonym so that individuals will not be identified. Only the Chief Investigator and his University supervisor will have access to the data. After 5 years all data are destroyed.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you may ask to speak to the researchers who will do their best to answer your questions (0121 414 3417). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure (or Private Institution). Details can be obtained either from your hospital or at:

[www.nhs.uk/Conditions/Complaints-about-NHS-services/](http://www.nhs.uk/Conditions/Complaints-about-NHS-services/)

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

If you become upset during the course of this research study, and feel as though you need to speak to someone about it, we will provide you with the details of someone who will be willing to talk to you about your difficulties. You can contact us using the details below or let us know during the interview.

### **Analysis**

A transcript of your interview will be typed up on a computer that is password protected, and your answers will be analysed and coded along with other people who have responded to our research. Different 'themes' that are common across the interviews will then be identified and these will be discussed in the report from the research. Quotes will be used to illustrate these themes, but they will be attributed to pseudonyms to protect confidentiality.

### **Who is organizing the research?**

The report is part of a doctoral dissertation in Clinical Psychology at Birmingham University, and will be included in the thesis of the Chief Investigator. You may request a copy of any report resulting from the data collected for this study by contacting the Chief Investigator, whose details are at the end of this booklet.

### **Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Trent Research Ethics Committee.

## **Initial Points of Contact**

### **Chief Investigator:**

**Andrew P Fox**

*Address here*

Telephone:

e-mail:

For independent advice on this research contact the Patient Advisory and Liaison Service (PALS) on 0800 953 0045 or 0121 678 4455 or [pals@bsmht.nhs.uk](mailto:pals@bsmht.nhs.uk).

### **Useful Contact Numbers**

The Samaritans (general helpline)	08457 909090*
--------------------------------------	------------------

SANELINE (mental health helpline)	08457 678000*
---	------------------

Mind (mental health information)	08457 660163*
--	------------------

Eating Disorders Association (beat)	0845 634 1414
---	------------------

NHS Direct (24 hour information line)	0845 4647
---	-----------

\*Calls charged at local rates

Please keep this information in a safe place and feel free to ask any questions.

### Appendix 3: Consent form



Title of Project: *The personal meaning of eating disorder symptoms*

Name of Researcher: *Andy Fox*

Please initial box:

1. I confirm that I have read and understand the information sheet dated February 2008, version 2 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected ☐

3. I understand that relevant sections of the data collected during the study, may be looked at by individuals from The University of Birmingham, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data ☐

4. I agree to take part in the above study ☐

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

If you there is anything you do not understand or if you have any questions, worries or concerns about the research please do not hesitate to ask them before, during or after you complete the questionnaires.

## Appendix 4: Participant cameos

*Due to ethical considerations, this section has been removed from the online version of the thesis.*

## Appendix 5: Interview schedule

### Part 1: History questions

Do you currently experience symptoms of anorexia/bulimia?

Could you tell me a little about your anorexia/bulimia?

How long do you think the anorexia/bulimia has been with you? (How long have you had the symptoms?)

When did you first realise that you had difficulties?

Did you know it was an eating disorder, like anorexia or bulima?

What other things do you/have you experienced that might not be understood by some as eating disorder symptoms?

### Part 2: Personal meaning (narrative) questions

If you could speak to your anorexia/bulimia, what would you say to it?

If your anorexia/bulimia could speak to you, what do you think it would say to you?

How do you feel about your anorexia/bulimia?

Is there anything in particular that you dislike about your anorexia/bulimia?

Is there anything in particular that you like about your anorexia/bulimia?

Does your attitude towards your anorexia/bulimia change over time, and if so, in what ways?

What are your thoughts on getting rid of the anorexia/bulimia?

What do you imagine life would be like without anorexia/bulimia? In what ways would things be different to how they are now?



## Appendix 6: Instructions for authors - British Journal of Clinical Psychology

*Due to reasons of copyright, this section has been removed from the online version of the thesis*

## Appendix 7: Instructions for authors: Journal of Health Psychology

*Due to reasons of copyright, this section has been removed from the  
online version of the thesis*

## Appendix 8: Sample of coded transcripts

P7 coding (4)

1 First of all, can I ask, how old are you?  
2 P7: 18  
3 I: You're 18  
4 P7: yeah  
5 I: and do you currently experience symptoms of anorexia or bulimia?  
6 P7: yeah, bulimia  
7 I: OK, bulimia, and what do you prefer - do have a name for it or what do you call it or...?  
8 P7: no, just bulimia  
9 I: just bulimia, you're ok with -  
10 P7: I've got some anorexia tendencies, but I've never been diagnosed with anorexia, but I've  
11 been diagnosed with bulimia  
12 I: ok, so you've got that stamp of diagnosed -  
13 P7: got that label, yeah [laughs]  
14 I: could you tell me a little bit about it then  
15 P7: yeah  
16 I: your bulimia - is it ok to call it the bulimia?  
17 P7: yeah, that's fine, it started when I was 14 erm, after, I was like sexually abused and then I  
18 stopped eating, at first of all it was like I didn't eat anything, just like an apple a day or something  
19 like that, for months, nobody really knew anything, umm, and then, I started passing out at school  
20 and stuff like that and they got involved and then it was all like, what's going on with X, and then  
21 they referred me to the mental health team, and then they were like, she's just got eating  
22 problems we'll just monitor her, erm and it carried on and then... I lost a lot of weight and then I  
23 was put into the hospital cos the therapy that they were doing wasn't really helping they were just  
24 seeing me regularly and so I was put as like a day patient for 4 days a week erm, and then it kind  
25 of just went on from there really  
26 I: ok, so -  
27 P7: and then then I started, when they started making me eat actually, [laughs] erm, I started  
28 eating and then making myself sick and that's how the bulimia came  
29 I: oh, ok  
30 P7: at first it wasn't really it was just like I stopped eating but when they started making me eat I  
31 was like, got I've gotta think of another way around this.  
32 I: ok, so you started off with restrictive symptoms to start with  
33 P7: yeah  
34 I: and how old was that did you say  
35 P7: 14  
36 I: about 14, ok  
37 P7: yeah

See you go!  
Some Anorexia  
But BV diagnosis.

excessive  
restriction  
School refusal  
die to psychosis  
they minimised  
diagnostic  
black & blue  
shift decide  
me eat  
they caused  
it (BV)

1 I: and erm, when did you first notice?  
2 P7: I noticed, well I noticed that I was like, I started like, yeah, a bit of a diet, you know but I  
3 restricted myself a lot, and like I'd say to friends I'm not eating that, and they'd  
4 be like ok that's quite a lot that you're cutting out, and I'd be like no it's just a diet and then  
5 eventually I realised when I was like, I'd lost about, I kept weighing myself every day like three  
6 times a day and all this and like pain in my head that I couldn't concentrate that all my mind was  
7 focusing on when am I gonna eat next, what am I gonna eat, how am I gonna go to pretend like my  
8 mum I've eaten and  
9 I: erm  
10 P7: stuff like that, and I think I didn't really see it as a problem at first, but friends did, and like at  
11 school, and it was other people that made me realise that it was a bit of a problem, but I was kind  
12 of in denial for a long time  
13 I: ok  
14 P7: for like months, really  
15 I: ok and that all started when you were about 14?  
16 P7: when I was 14, yeah  
17 I: there was no kind of run up?  
18 P7: no before my eating was absolutely fine  
19 I: for anything like that, ok  
20 P7: absolutely fine  
21 I: ok, ok, and then, 14, stuff happened and then that -  
22 P7: yeah, and I think it was like erm, control like, in my head, when I was concentrating about  
23 eating I wasn't thinking about anything else, but my eating!  
24 I: ok  
25 P7: it was like, it blocked my mind off everything else that I didn't want to think about  
26 I: ok  
27 P7: maybe  
28 I: ok, um, and so, your 18 now, so how long do you think it's been with you?  
29 P7: 4 years?  
30 I: 4 years, yeah  
31 P7: I've gone through phases where it's ok  
32 I: ok  
33 P7: like erm, when I was about, last... not like these last 6 months, but before that, for about 6  
34 months, I was absolutely fine and my eating was normal.  
35 I: erm-hm  
36 P7: I wasn't making myself sick or anything  
37 I: ok

frustrated  
Died to starve  
with  
Excessive  
weighing  
hair in  
heart  
Did not  
recognise  
problem.

Eating fine before.  
Distraction  
brain noise  
Black out  
trauma.

Phases of no ED since 16.  
Previous  
bulimic  
ok.  
No variety (much of 2  
illnesses?)

1 P7: but it's only recently that say, like the last 6 months that it's come back again  
2 I: ok  
3 P7: erm, but I had a phase where I was ok, I didn't really have any help or anything... erm and I  
4 was alright  
5 I: ok, and when did you first realise that you had difficulties?  
6 P7: erm... wh... I think it started when, it started when I was like, when I was, in May time, and  
7 then I didn't realise until I was admitted to the hospital until really I was like, ok, I've got a problem  
8 I: ok, and what was it that made you realise that you had some kind of  
9 P7: erm, well at first I was like everything's fine and it's not, but then I ended up on a drip and  
10 then I saw my mum, and she was devastated and I was like ok, this isn't normal  
11 I: ok  
12 P7: from that point I started like, wanting to get better, cos even when I was admitted to hospital I  
13 was still like, you can't make me eat, you're not doing, y- whatever you do you're not gonna help,  
14 erm, and then, when I was put on the drip, then it made me realise, it had to go to like that  
15 extreme  
16 I: yeah  
17 P7: really, so  
18 I: cos it sounds like there was, there was 2 phases then, the first phase which is the... not wanting  
19 any help  
20 P7: mmm  
21 I: and then the second phase which is like recognising?  
22 P7: yeah  
23 I: you've got a problem  
24 P7: yeah  
25 I: how long was that first phase?  
26 P7: erm, [counts the months under breath] may, June, July, August, September, about 5 months  
27 I: 5 months  
28 P7: yeah  
29 I: you didn't really recognise you had anything  
30 P7: yeah, but with what happened to me, I when I was admitted to hospital, I told a nurse, and  
31 that was the first time I spoke about it, and no-one else knew cos I kept it a secret, and it was that  
32 time when I was put on, all around that time that I was put on a drip and all that that!  
33 I: ok  
34 P7: I: telling someone what happened to me as well, made me realise what I'd been doing  
35 I: ok  
36 P7: so, it was like coming out with what had happened

ED returned  
Coped on my  
own -  
Admitted to  
hospital  
= realisation  
Nurses reaction  
realised.  
Put on drip  
changed  
at look.

Swaths  
of denial.  
First time  
told someone  
(in hospital)  
'coming out'  
3

1 I: and do you know why you decided, or what it was that was going on that made you decide to  
2 tell the nurse?  
3 P7: erm... I think I was just such a mess, I was having panic attacks and like flashbacks of what  
4 happened, and no-one really knew what was going on, and I thought I'm gonna have to tell  
5 someone cos they're not, they have no idea what what's going on when I'm like having these  
6 panic attacks and stuff, they always thought it was like to do with the eating or like, eating, and I  
7 was like no I'm having like a flashback,  
8 I: ok  
9 P7: and they'd be like, well, what about, they don't, don't understand  
10 I: ah, ok  
11 P7: I had to, it was like no choice, really,  
12 I: yes, so you like explaining this to them  
13 P7: yeah  
14 I: and um, did you know it was erm, an eating disorder?  
15 P7: erm... yeah, I think cos as well, I was surrounded by there was like 4 other people on the  
16 ward that had it, had like!  
17 I: ah, so like a specialist ward  
18 P7: eating disorders, yeah and I could see it in them and I was like I'm clearly here for a reason,  
19 I: right  
20 P7: but they had really, like extreme anorexia, whereas I was like the only one with bulimia,  
21 I: mmm  
22 P7: so it was a bit different, but, whereas I'd be like, so they're so much more skinnier than me,  
23 so I'd be like they're the ones with the problem, even though I was I'd lost a lot of weight at the  
24 time  
25 I: yeah  
26 P7: I was always like, look at her, she's got the problem, not me.  
27 I: mmm  
28 P7: I'm not that fat yet, but  
29 I: ok  
30 P7: I was kind of still in denial a bit when I looked at them, but realising that I was actually in a  
31 hospital  
32 I: yeah  
33 P7: I think if I was still at home having therapy, like, once a week or something I don't think I  
34 would realise, I think I'd be like I'm fine still  
35 I: so it was the hospital that kind of /  
36 P7: yeah that environment

Trauma slash shocks.  
Told them  
so they  
would understand  
Not 'just'  
an ED.  
explained  
phase?  
Others with  
ED in hospital  
so realised.  
BN vs  
AN  
AN's are worse  
for now...  
Yet!  
Hospital environment  
changed + used  
me realise 4

P10 Coding 01.

①

sees as a medical condition

way of life  
H. life = ED.

1 I Do you currently experience symptoms of anorexia or bulimia?  
2 P10: Yes, erm, do you want me to say what?  
3 I: yeah, yeah, tell me a bit about them  
4 P10: erm, I restrict, I binge, I vomit, erm, I sometimes use laxatives  
5 I: ok  
6 P10: things like that  
7 I: ok so it's restriction and bingeing and vomiting as well  
8 P10: yeah  
9 I: ok, erm, and how often do you binge, vomit?  
10 P10: er, it varies, sometimes it can be a couple of times a week, and sometimes it can be I can go for a couple of weeks without doing it  
11 I: ok, ok, and erm... how long has it been in its current state?  
12 P10: um... probably about half a year  
13 I: half a year, ok, and how long have you had what you would call eating difficulties, or difficulty for about 5 years  
14 I: about 5 years, and your 20 now, so  
15 P10: yeah  
16 I: um, that's just so I remember for the thing, um... so about 5 years  
17 P10: yeah  
18 I: and have they... how did they start, what for did they take at the beginning?  
19 P10: um, well I had OCD since I was about 8.  
20 I: ok  
21 P10: and um, I suppose the first thing I developed a fear of getting sick, um, so when I would go to places that were particularly difficult, I was particularly worried I was going to feel sick or be sick, I would um, I wouldn't eat, and then it went into that and I kind of progressed from there  
22 really... um, but when I was 15 my granny died and someone I was very close to was diagnosed with breast cancer, and um, I just started restricting  
23 I: mmm  
24 P10: and then when I was made to eat again I went into bulimia  
25 I: ok so the restriction started first  
26 P10: yeah  
27 I: out of the current stuff, do you still have the OCD?  
28 P10: yeah  
29 I: ok, so that's always been around since you were younger  
30 P10: yeah  
31 I: and what erm... what was I gonna ask, um... can you tell me a little bit about the restricting and the bingeing vomiting work together, if they do

Allied to everything

it's a

AN/AN.

terminology

cycles of AN + BN

5 yrs long

obsessive

fear of death

her reasons for eating disorder

death - resist, afraid

her not in common

forced to eat - bulimia

OCD around

1 P10: um, well I think the bingeing/vomiting probably come from the restricting  
2 I: ok  
3 P10: um, restricting generally revolves around limiting my calorie intake and um, basically it's feeling full and I'm very very limited as to what I will actually eat, which is probably only about 4 or 5 things, and um... and then I'll drink a couple of types of drink, but that's a really... um, and then the bingeing and vomiting kicks in and I would never ever eat any of the things I eat if I wasn't out of control, and then I purge them  
4 I: mmm, and generally that's vomiting but also laxatives and stuff like that  
5 P10: sometimes, but because I've always been [laughs] always been able to throw up pretty easily, it wasn't a problem and I can do it without sticking my fingers down my throat so it's not even difficult  
6 I: ok  
7 P10: it's just something that I've learned to do really... a skill  
8 I: ok, erm, when did you first realise that you had eating difficulties?  
9 P10: probably when I was about 15, and... and I think I probably realised pretty quickly because I was, I became very very entrenched very very quickly, which was the thing that was so frightening, um, literally within, I think... I think within a month or 2 I wouldn't have been able to eat  
10 I: mmm  
11 P10: and of it really being quite full on, I wouldn't have been able to have stopped and I think that was probably, I realised pretty quickly then that I was probably in a bit of trouble  
12 I: ok, and was it a conscious decision not to eat, when you were 15?  
13 P10: no, and this is the weirdest thing of all... I, I kind of just... it just seemed like a good idea at the time, I just decided that it was almost like a project, by the summer kind of thing, and it wasn't even to lose weight, it was just I wanted to control how much I was eating and... it wasn't, I mean some people say they started off feeling full or something, and yeah I had put on some weight, and yes that was bothering me because I think I had probably, um, comfort ate a bit during, um the time when my granny was very very ill, but it wasn't like I feel fat I'm gonna go on a diet  
14 I: mmm  
15 P10: it was... I dunno, it seemed like a thing to do or something, I don't know why I started, and I kind of wish I hadn't [laughs] but not sure  
16 I: ok, and it was the restriction that started doing  
17 P10: yeah  
18 I: do you remember what it was you started doing first of all?  
19 P10: erm, I started calorie counting first and I went to Malaysia, with my parents for a month, and my brother and my sister, and um, it wasn't even calorie counting to begin with it was just restricting the amount of food and seeing how little I could run on, it wasn't, wasn't formal it

easy day to vomit

a skill

scored

scored project

project

project

but not sure

scored

dear

grill

intense

intense

intense

intense

intense

intense

ad  
and  
very  
nerv  
e  
near

③  
No family history

Completed ④

1 wasn't... you know, there was no knowledge based on it, I didn't come from a family that dieted at all, I didn't come from a family that put any emphasis on shape and weight, just decided that this was what I was going to do...  
2 I: mmm  
3 P10: and that's what happened  
4 I: any idea where you got the idea from?  
5 P10: I don't know  
6 I: I just picked it up and ran with it  
7 P10: yeah [laughs]  
8 I: ok, um, and how long did it take until you started the bingeing and vomiting, because it was 15  
9 P10: yeah, erm, well I started in probably the summer of June in 2003, I think, properly, and um... I was stopped a bit in October, because I basically had a breakdown, so I probably overate a bit to gain back the some of the stuff that I'd lost, weight that I'd lost up until December when I started again restricting, but the bingeing and vomiting probably, I binged a bit and then I started vomiting in November 2004 I'd say probably  
10 I: ok  
11 P10: so it was quite a period, and I did go into basically, I suppose, overeating until from about, probably about July or August 2004 until November  
12 P10: and then I started vomiting cos I couldn't do it anymore, and again that wasn't cos I'd read it in magazines, it was cos it was something I felt I needed to do [laughs]  
13 I: ok  
14 P10: so... it was pretty weird  
15 I: and how did you come to the decision to vomit?  
16 P10: I don't know it just became an increasing urge to just to get rid of it, or not even to get rid of it, I'd do it and... eventually I did it, and the first time I did it I was sort of really shocked that I'd done it and I confessed to my parents that I'd done it and then very quickly about a couple of weeks or months later I did it again and then I kept on doing it and didn't stop  
17 I: ok and so it's when, what do you think started the bingeing off?  
18 P10: um, I'd lost a lot of weight in, well, not a lot of weight, but I'd lost a fair amount of weight in not very long time and um, I was basically, huh, made to start eating again, and um, it wasn't done in a methodical way, it was done by my mum and day trying to stop me from being admitted into services or anything, not  
19 I: ok  
20 P10: admitted into hospital but admitted into services  
21 I: yeah, yeah

life goal burden?

Not sure where idea came from

very crazy

very crazy

very crazy

very crazy

very crazy

very crazy

very crazy

very crazy

very crazy

very crazy

1 P10: and um... so, I ate for a while what my mum and dad gave  
2 I: mmm  
3 P10: but when you've, when you've restricted and then you start eating again, you go out of this sort of numb state and you go into where you are actually hungry and I just went out of control  
4 I: ok  
5 P10: so [laughs] I ate all the time and it was horrible  
6 I: ok, so it sounds like you've kind of, your hunger came back type thing.  
7 P10: yeah and because there was no, there was no process to doing it  
8 I: yeah  
9 P10: I just binged basically, the whole time  
10 I: ok, and the vomiting was a way to get rid of the  
11 P10: yeah  
12 I: stuff you'd eaten, to kind of compensate type thing  
13 P10: there was no, I've heard other people say like, um, oh it was great as I found out I could eat and get rid of it at the same time [there was none of that] Oh's better than (P10)  
14 I: ok  
15 P10: I was really really wanted to go back to the restricting, and I couldn't manage to get myself to go back to restricting, and I decided that if the bingeing was never put out, at least had to get rid of it  
16 I: mmm  
17 P10: there was no yay, it means I can eat, it was, I'd just throw it back up again until I go back to restricting  
18 I: ok  
19 P10: so  
20 I: and then since then has it been that way  
21 P10: pretty much, yeah  
22 I: the restriction and... and um, ok, and I mean you mentioned that ocd came first, didn't it?  
23 P10: mmm  
24 I: about vomiting  
25 P10: yeah  
26 I: um, when you started to have eating difficulties, did you know it was what people would call an eating disorder?  
27 P10: um... I think I did after a bit, um, probably not at the beginning  
28 I: mmm  
29 P10: once, I suppose once people started to get a bit panicked then I probably did not it was probably not quite normal behaviour  
30 I: mmm

out of control

could not stop

constant binge so had to vomit

different

recal

tried to

tried to

tried to

tried to

tried to

tried to

tried to

benzene is well - legend

entrenched mind

needed to keep myself

needed to keep myself

needed to keep myself

needed to keep myself

needed to keep myself

needed to keep myself

needed to keep myself

needed to keep myself

OCD first

Did not realize it was ED

recognised brain illness